THE THEORISATION OF SUICIDE:

AN EXPLORATORY STUDY

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ABSTRACT

This thesis is a conceptual exploration of a number of issues relevant to the theorisation of suicide. Five research questions are addressed. 1. How should suicide be defined? It is argued that intentionality is central to an understanding of suicide. Suicide is defined as ending one's own life intentionally. 2. Why is there a proliferation of theories of suicide? Three main sources are identified - the complexity of suicide, the existence of different disciplines, and the significance of different basic theoretical perspectives. 3. Should this theoretical pluralism be accepted as normal or should theoretical unification be the goal? Theoretical unification is rejected because it denies the complexity of suicide, treating it as an undifferentiated domain, and imposes one theoretical perspective at the expense of others. 4. How are studies of the various explanatory factors of suicide shaped by different disciplinary concerns and the assumptions made by different theoretical perspectives? Different disciplinary approaches have focussed on the operation of different factors, and theoretical perspectives within each discipline offer different understandings of the meaning of such factors. The theorisation of suicide must resist the fragmentation of disciplines, theoretical perspectives, and various reductionisms in order to understand suicide as a holistic phenomenon existing at a number of ontological levels. 5. Is it possible to develop an integrated overall theory of suicide? Different explanations are required for

different types of suicide, human behaviour is not law-governed, and psychological and social reality consists of open systems. For these reasons, a global theory of suicide is only able to consist of a highly generalised account of the range of distal and proximal factors potentially relevant to the range of types of suicide. Work by Shneidman (1985) and Maris, Berman and Maltsberger (1992) offer a basis for such a global theory.

ACKNOWLEDGEMENTS

Suicide in New Zealand has received very little attention from researchers despite the fact that this country has very high rates of suicide in international terms. Young people especially are likely to know someone who has committed suicide. This thesis arose out of my awareness of this as well as a belief that theory was important in contributing to a better understanding of the causes of suicide. When it became clear that the literature on theories of suicide contained great diversity, the challenge before me was to make some sense of it.

I would like to thank Dr Brian Haig of the Department of Psychology, University of Canterbury, who was the main supervisor of this thesis. After I moved from Christchurch to Auckland in the middle of 1996, he remained interested and supportive despite the intervening distance. As well as providing comments on drafts of the thesis, he pointed me to the Canterbury Suicide Project as an important empirical study of suicide in New Zealand. Dr Stephen Hudson in the same Department provided an important series of comments on the final draft, many of which proved particularly helpful. His paper, written with Tony Ward, on theory and sexual offending, became the model for a significant section of chapter five. I am grateful to Annette Beautrais, Principal Investigator for the Canterbury Suicide Project, for her willingness to discuss the Project with me and for sending me copies of the Project's research papers. After moving to Auckland, I was fortunate to receive the support of John Paterson of the Social Science Research Programme at the University of Waikato. He provided an important sounding board for my ideas and made a number of useful suggestions about aspects of the study. He also provided valuable support at the time of the completion of the final text.

I would like to acknowledge the significance of my father's inspiration and encouragement throughout my tertiary studies. Others who have been important in providing personal support in Christchurch and Auckland include Christine, Andrew, Adele, Heather and Hogan. This thesis is dedicated to my mother who died in 1989 after several years of illness. She instilled in me the belief that I could accomplish my goals through perseverance.

CHAPTER I

INTRODUCTION

Cathy's husband, a Tongan, living in Wellington, hanged himself in the basement of the family home after saying he was going to put the dog out. Why did he do it?

> Cathy says the basic problem was low self-esteem. Her husband had a good job, they owned a house, but he still felt he should be doing better for his wife and family. As depression and bad moods grew...he came to feel they would be better off without him (Neville, 1989, August, p. 61).

However, Cathy was not completely satisfied that low self-esteem in itself fully explained why her husband committed suicide. What other factors could have been involved? Why did he develop such low self-esteem? Why did low self-esteem cause him to commit suicide when others with the same problem do not?

> In her continuing search to understand her husband's suicide, Cathy visited Tonga [in 1988, the year following his death]...to learn more of his culture and background. Still she looks for reasons, in spiritual and religious areas and in his medical history (Neville, 1989, August, p. 61).

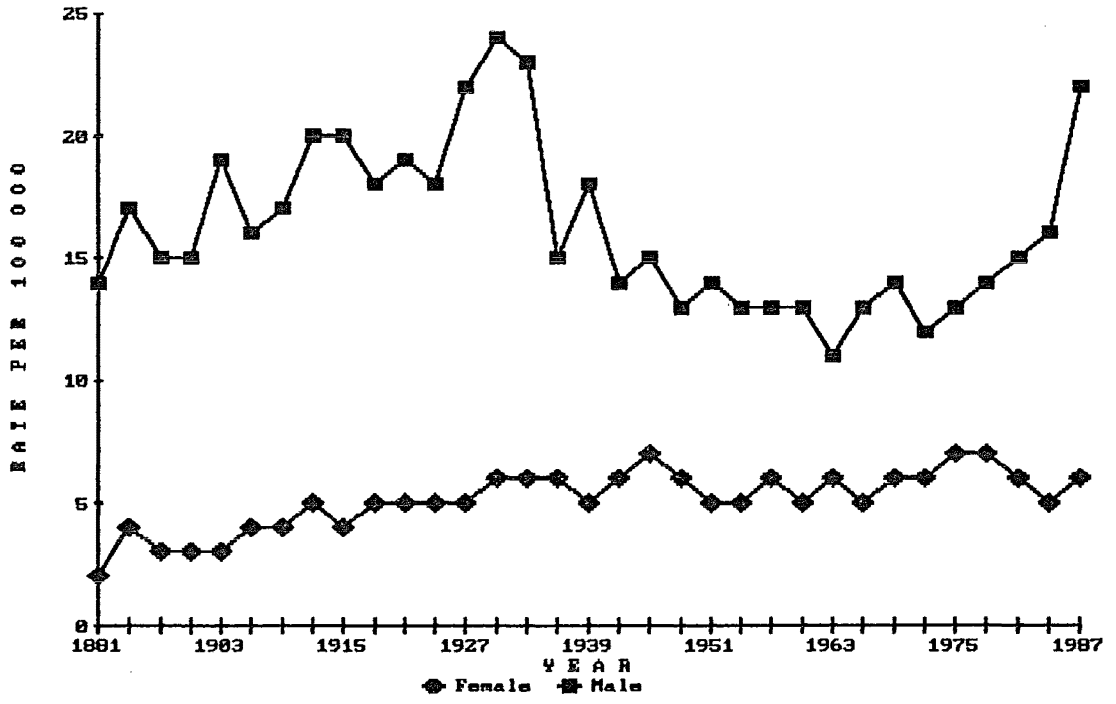
The relatives of suicide victims commonly embark upon a search for the reasons why people kill themselves. Academic researchers have also expended a lot of energy in the search for satisfying explanations for suicide. They often investigate the significance of sociological, psychological and psychiatric factors. However, it has been just as difficult for them to specify clearly the cause of suicide, whether it be in the operation of one factor or the interaction of many.

The rest of this introductory chapter examines the research conducted by the Canterbury Suicide Project, the most significant empirical study undertaken to date of suicide in New Zealand. A number of questions arise out of this examination relating to the difficulty of explaining suicide. They point to the need for a theorisation of suicide that is able to embrace satisfactorily the range and complexity of explanatory factors. At the end of this chapter, five research questions are formulated which are then addressed in detail in the rest of the thesis.

A study of the history of suicide patterns in New Zealand has been conducted by researchers associated with the Canterbury Suicide Project. Their historical study has relied upon two main explanatory approaches, one sociological, the other psychiatric (Deavoll, Mulder, Beautrais and Joyce, 1993). The following account of the project shows how these two approaches have been used.

As part of preparatory research for the Canterbury Suicide Project, patterns of suicide in New Zealand were examined during the 100 years from 1889 to 1988 (Deavoll et al., 1993) (see Figure 1).

Figure 1 : New Zealand Suicide Rates, Male and Female: 1889 - 1988 (Deavoll, Mulder, Beautrais & Joyce, 1993, p. 82).



During this time the rate of suicide by males has been markedly and consistently higher than the rate of suicide by females. For most of the last 100 years the male rate of suicide has been five times the female rate of suicide. The female rate climbed from a low of about 3 per 100 000 in the early 1890s to about 6 per 100 000 around the time of the Great Depression in the early 1930s and has remained remarkably constant since (Deavoll et al., 1993). The male rate rose steadily from the late 1890s to 1911-1916, then stabilised until the dramatic increase in the late 1920s and the early 1930s coinciding with the Great Depression. The

rate fell until the mid 1960s, but since then the male rate has risen at an increasing rate.

Comparisons with studies from other countries that have looked at suicide over the last century reveal interesting similarities and differences (Diekstra, 1989). The rise in suicide rates in Europe and the United States about 1910 among young men and women is absent in New Zealand and the dramatic 1910 peak in total suicide rates in the United States was also not present in New Zealand (Deavoll et al., 1993). The 1930s peak in overall male suicide rates appears to have been present in both New Zealand and the United States, as are the low rates after 1945 (Deavoll et al., 1993).

The peak in the New Zealand male suicide rates in the 1930s was accounted for by increased suicide rates among middle aged and older men, particularly those in the 45 to 64 year ages. However, the current increase in male suicide rates is accounted for largely by increased rates of suicide among younger men, those aged 15 to 24 years (Deavoll et al., 1993) (see Figure 2). Figure 3 illustrates that among women, the most substantial change is again the 15 to 24 year age group increases, and the lowering of the 45 to 64 year old and 65 plus rates over recent years.

A sociological, macroscopic theory is one explanation offered by Deavoll et al. (1993) to account for regional and temporal fluctuations in New Zealand suicide rates. This explanation

Figure 2 : New Zealand Male Suicide Rates
By Age Group, 1889 - 1988
(Deavoll, Mulder, Beautrais & Joyce, 1993, p. 82).

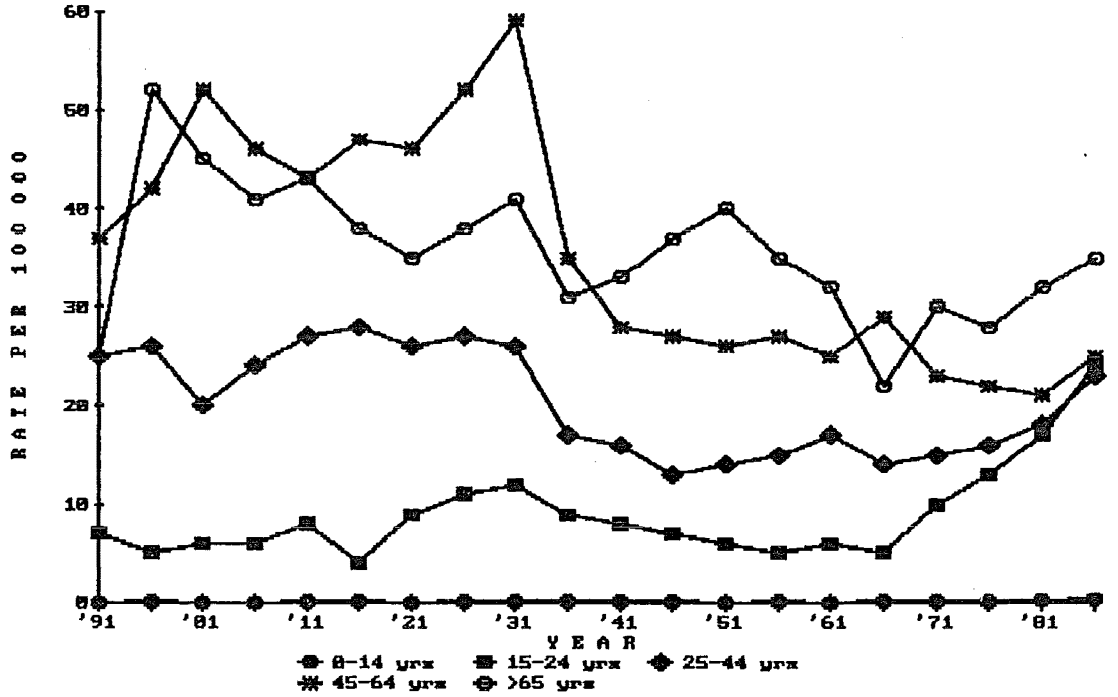
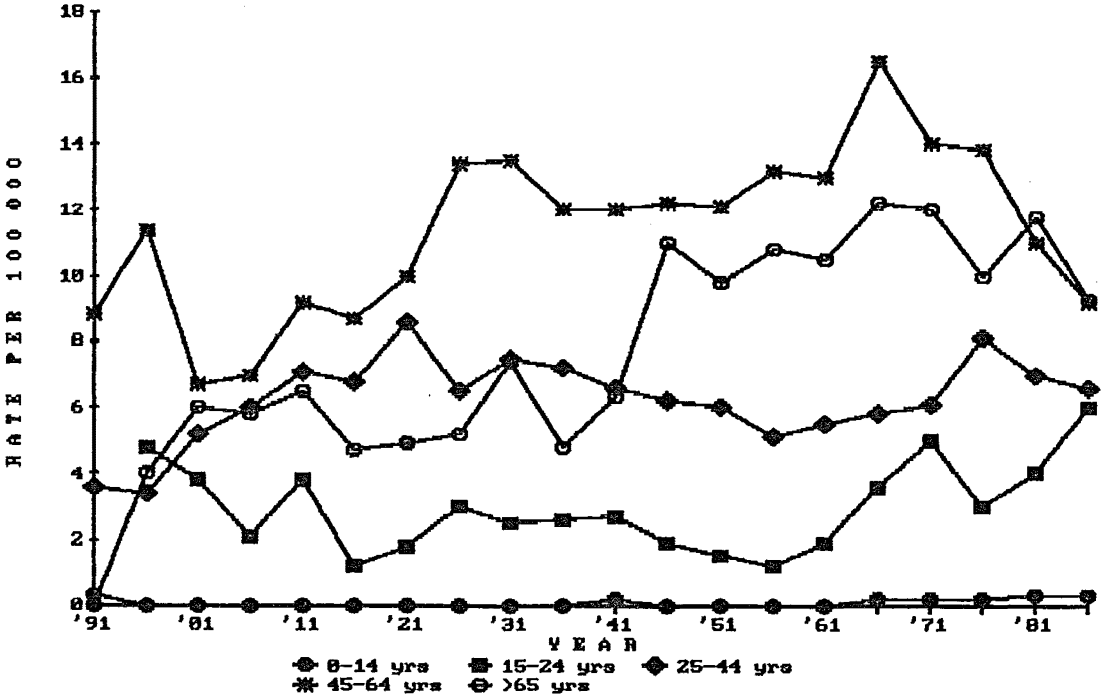


Figure 3 : New Zealand Female Suicide Rates
By Age Group, 1889 - 1988
(Deavoll, Mulder, Beautrais & Joyce, 1993, p. 83).



stems from Durkheim's account of anomic suicide, a form of suicide which results from an insufficiency in people's ability to integrate into the societal collective. At times of economic crisis, there is an increase in activity and an amplification of the interaction and competition between individuals. Deavoll et al. (1993) have suggested that, for some individuals, there is an increasing discrepancy between their aspirations and satisfactions, which may be worse if there has been a prolonged period of economic stability with rising expectations of prosperity prior to the crisis. The atmosphere of restlessness and dissatisfaction favours the growth, in vulnerable individuals, of suicidal ideation (Deavoll et al., 1993).

The use of the Durkheimian sociological approach leads to an investigation into links between New Zealand's social and economic history and historical patterns of suicide. Around the turn of the century, New Zealand was a largely agricultural economy in a new colony, full of the promise of peace and prosperity for the large numbers of immigrants arriving from (predominantly) Great Britain, with ready overseas markets for primary produce. Women's suffrage had been achieved 15-20 years before and, from the outset, New Zealand had a secular rather than religious base (Deavoll et al., 1993). The Great Depression of 1927 to 1933, however, caused enormous social upheaval with high unemployment and poverty. Subsequent to this, New Zealand developed an advanced social welfare system and enjoyed 40 years of economic prosperity and full employment, supplying Great

Britain and the world with its agricultural products. The oil crisis of the early 1970s, the formation of the European Economic Community and increasing protectionism in world markets has created a substantial constriction in the current New Zealand economy with the result that unemployment is now higher than even the 1930s and still rising (Deavoll et al., 1993). Deavoll et al (1993) have pointed out that it is difficult to deny that the suicide rates and periods of economic recession and unemployment in New Zealand parallel each other.

Employment differentially affects men far more than women and it is notable that the female suicide rate has essentially remained unchanged by economic upheavals in New Zealand. However, Deavoll et al. (1993) have suggested that this sociological explanation is not sufficient to explain why the 1930s peak was due largely to suicides in older men and the current peak to suicides in younger men. They have argued that, in the last three to four decades, young men, in particular, have been raised with high expectations and experienced a continual rise in living standards, which may have made them particularly vulnerable to anomie. There is a need then to look to the influence of non-sociological types of factors to account for suicide historically in New Zealand.

Deavoll et al. (1993) have supplemented their sociological studies by drawing upon a psychiatric approach. In this approach, the focus is on psychological disorders and mental

illnesses, some of which may be traced to biochemical origins. Thus the focus moves from the influence of the wider social context to the influence of an individual's inner psychological processes.

Researchers have noted that it is difficult to know whether rates of mental disorder (especially depression and alcoholism) have fluctuated over the century in New Zealand, but there is increasing data that supports the idea that rates of depression are increasing and that it is occurring at younger and younger ages (Klerman, 1988; Klerman & Weissman, 1989). These birth cohort trends in depression have been identified (Joyce, Oakley-Browne, Wells, Bushnell and Hornblow, 1990). There is also increasing prevalence of alcohol abuse and dependence for each male and female cohort from age 15 onwards in New Zealand, consistent with the doubling of national alcohol consumption since 1945 (Wells, Bushnell, Joyce, Hornblow and Oakley-Browne, 1991). Interestingly, alcohol consumption appeared to decrease around the time of the Great Depression, which probably reflects the poverty of the time (Deavoll et al., 1993). Consequently, this suggests that alcohol was not an influential factor in suicide during the 1930s (Deavoll et al., 1930).

Shaffer (1988) has postulated that, for teenagers, the combination of substance use, depression and conduct disorder may be a lethal combination and that increases in the rates of these disorders may explain the increase in teen suicides

over the last 20 years. Robins (1986) has also shown that rates of conduct disorder in the United States may have increased over the last 50 years, and a similar pattern of increasing conduct disorder is apparent in New Zealand (Deavoll et al., 1993). In general, there appears to be more difficulty in identifying the significance of psychiatric as opposed to sociological factors in suicide historically in New Zealand, but this is at least partly a function of the availability of good data.

Deavoll et al. (1993) acknowledge the sociological and psychiatric approaches to suicide are seldom adequately integrated. They suggest that further examination of trends in suicide rates over the last 100 years may assist in determining the relative importance assigned to each. In New Zealand, the increase in male suicide rates around the 1930s and 1980s, and the lower rates between these periods, is consistent with the prevailing social, economic and employment condition of the society. However, Deavoll et al. (1993) conclude on the basis of psychiatric autopsy studies that mental disorder is a vital intervening variable. This conclusion suggests a complex explanatory account of suicide which requires careful theorisation of the relationship between qualitatively different factors, that is, between factors usually dealt with by the different disciplines of sociology, psychology and psychiatry.

The Canterbury Suicide Project has also been conducting a large-scale study on contemporary suicide in New Zealand.

Between 1991 and 1996 the Project had completed approximately 4,500 interviews with subjects, their families and friends, general practitioners, and mental health professionals. The suicide sample was collected within the Canterbury region, based upon verdict of suicide given by the coroner. Serious attempted suicides consisted of individuals who made attempts for which hospital admission for at least 24 hours was required. In addition individuals who made serious attempts by methods with a high risk of fatality, such as hanging and gunshot, who did not meet the above criteria were also included in the serious attempts group.

The Project has been engaged in two separate but related studies of contemporary suicide, one a case-control study of suicide and serious attempted suicide, the other a longitudinal study of serious attempted suicide. The first study uses a multiple group, case-control design in which three groups are compared: individuals who have completed suicide, individuals who have made serious suicide attempts, and an age and gender stratified sample of control subjects randomly selected from the electoral rolls for the Canterbury region. Those who have died by suicide and those who have made serious attempts are compared with control subjects with respect to a range of background factors including, psychiatric illness, physical health, social and psychological characteristics to the risk of suicidal behaviour. A detailed investigation has been made into the significance of the two sets of factors explored in the historical study, the sociological and the psychiatric.

On the sociological side, Beautrais, Joyce and Mulder (1996) examined the risk factors for serious suicide attempts in young people aged 13 to 24 years. Their sample consisted of 129 young people who had attempted suicide, contrasted with 153 randomly selected subjects controlled for age and gender. Their study confirmed findings from previous research which has shown associations between a range of sociodemographic factors and risk of suicidal behaviour in both adults and adolescents (Dubow, Kausch, Blum, Reed, and Bush, 1989; Petronis, Samuels, Moscicki, and Anthony, 1990). Beautrais et al. (1996) found that odds of serious suicide attempt were elevated among individuals who were less well educated, more residentially mobile, and had lower annual incomes than the control subjects. However, unemployment was not associated with risk of serious suicide attempt when the effects of poor educational qualifications, low income, and residential change were taken into account.

The findings of Beautrais et al. (1996) were also consistent with other studies which have indicated that a range of childhood experiences and family adversities contribute to increased risk of suicidal behaviour (Fergusson and Lynskey, 1995; Smith and Crawford, 1986). The Canterbury study showed that when the intercorrelations between family risk factors were taken into account, odds of serious attempt were elevated among those individuals with histories of childhood sexual abuse, low parental care, and poor parental relationship. However, when the effects of correlated

childhood experiences were taken into account, reports of high parental control, physical abuse, parental separation, parental violence, parental alcohol problems, parental imprisonment, poor family economic circumstances, and being in care during childhood were not associated with risk of serious suicide attempt.

In a consideration of the psychiatric dimension of contemporary suicide in New Zealand, Beautrais, Joyce, Mulder, Fergusson, Deavoll and Nightingale (1996), compared the prevalence and comorbidity of a range of mental disorders in a consecutive series of 302 individuals who made serious suicide attempts and in a series of 1028 randomly selected control subjects. The aim was to examine the relationship between psychiatric illness and risk of serious suicide attempt. A serious suicide attempt was defined as those for which the individual required admission to hospital for more than 24 hours for specialised medical and surgical care.

Figure 4 compares rates of mental disorders in the preceding month for those who make suicide attempts and for control subjects. The incidence of psychiatric disorder was high with 90.1% of those who make serious suicide attempts having at least one mental disorder compared to 20% of control subjects. It has been frequently reported that approximately 90% of those who die by suicide have a mental disorder at the time of their death, and the present study suggests that the prevalence of mental disorder is similarly high for both completed suicide and serious suicide attempts. The

incidence of comorbidity was also high, with 43.4% of those who made serious suicide attempts having two or more mental disorders, compared to 3.5% of control subjects.

Figure 4 includes the odds ratios associated with each mental disorder category. (The odds ratio (OR) describes the strength of associations between a risk factor and outcome). Figure 4 shows strong associations between a range of mental disorders and risk of serious suicide attempt. Those individuals with a diagnosis of depression in the month prior to the suicide attempt, for example, were 27.2 times more likely to make a serious suicide attempt than those without depression.

Overall, individuals with any mental disorder diagnosis were 35.3 times more likely to make a serious suicide attempt than those without mental disorders. However, Beautrais et al. (1996) also suggest that the risk of suicide attempts further increases with the comorbidity of mental disorders. Figure 5 illustrates the relationship between the number of mental disorders and the risk of a suicide attempt for members of each age-and-gender stratum and for the total sample.

For all age-and-gender strata, there was a marked gradient in the risk of a serious suicide attempt conditional on the extent of psychiatric morbidity. For the total group of subjects who make serious suicide attempts, more than one-half (56.6%, N=171) met the criteria for two or more of the

Figure 4 : Rates of Mental Disorder Among Subjects Who Made Serious Suicide Attempts and Comparison Subjects. (Beautrais et al., 1996, p.2).

Mental Disorder During Prior Month	Serious Suicide Attempts (N=302) N	%	Comparison Subjects (N=1,028) N	%	OR
Mood disorders					
Major Depression	187	61.9	58	5.6	27.2
Bipolar I or II Disorder	44	14.6	10	1.0	17.4
Any Mood Disorder	232	76.8	68	6.6	46.8
Substance Use Disorders					
Alcohol abuse/dependence	94	31.1	88	8.6	4.8
Cannabis abuse/ dependence	28	9.3	18	1.8	5.7
Other drug abuse/ dependence	30	9.9	2	0.2	56.6
Any Substance Disorder					
Anxiety Disorders (Panic disorder, with or without agoraphobia; simple phobia; social phobia; agoraphobia without panic disorder)	71	23.5	52	5.1	5.8
Eating disorders					
Anorexia nervosa	12	4.0	1	0.1	42.5
Bulimia nervosa	17	5.6	2	0.2	30.6
Any Eating Disorder	22	7.3	3	0.3	26.8
Nonaffecitve Psychosis (schizophrenia disorder, psychotic disorder not otherwise specified)	3	1.0	2	0.2	5.1
Antisocial Disorders During Lifetime (conduct disorder; antisocial personality disorder)	93	30.8	46	4.5	9.5
ANY MENTAL DISORDER	272	90.1	210	20.4	35.3

Figure 5 : Relation of Number of Mental Disorders to Odds of a Serious Suicide Attempt, by Gender and Age. (Beautrais, Joyce, Mulder, Fergusson, Deavoll & Nightingale, 1996, p. 1013).

	Men				Women					
	Age <30 Years		Age ≥30 Years		Age <30 Years		Age ≥30 Years		Total Group	
Number of DSM-III-R Disorders	Odds Ratio	95% Confidence Interval	Odds Ratio	95% Confidence Interval	Odds Ratio	95% Confidence Interval	Odds Ratio	95% Confidence Interval	Odds Ratio	95% Confidence Interval
None	1		1		1		1		1	
One	11.4	4.7–27.4	13.4	5.0–35.8	12.7	5.2–31.1	26.3	11.3–61.5	17.4	11.2–27.1
Two or more	56.6	21.4–149.5	92.3	32.8–259.6	48.8	19.0–125.2	113.3	44.6–287.9	89.7	55.6–144.7

six diagnostic categories considered in the analysis, compared to 5.1% (N=52) of the comparison subjects. Those who had two or more disorders had odds that were 89.7 times the odds for those with no disorder.

Beautrais (1996) concluded that these results imply that the extent of psychiatric comorbidity is strongly associated with the risk of a serious suicide attempt. Estimates of population attributable risk suggested that elimination of all mental disorders considered in the analysis (mood disorder, substance use disorders, anxiety disorders, antisocial behaviours, eating disorders and nonaffective psychosis) would result in a reduction of 76.2% in the total number of suicide attempts.

Studies by the Canterbury Suicide Project have showed that, when due allowance was made for intercorrelations between comorbid mental disorders, odds of serious suicide attempt were elevated among individuals with diagnoses of affective disorders, substance use disorders and antisocial disorders (Beautrais et al., 1996). However, anxiety disorders were

not associated with risks of serious suicide attempt when the effects of correlated disorders were taken into account.

The dominant profile of youthful serious suicide attempters that emerged from the study by Beautrais et al. (1996) was of a group of young people who had many disadvantages. In comparison with control subjects, their childhoods and adolescences were characterised by poor parental care and unhappy family circumstances. They lacked formal educational qualifications and were poorer, more residentially mobile, and more likely to have a depressive disorder, to be abusing alcohol and/or drugs, and to have exhibited antisocial behaviours. The general impressions conveyed by this profile are that medically serious suicide attempts among young people are largely the destination of unsatisfactory life courses characterised by childhood adversity, limited life opportunities as a young person, and the development of significant psychiatric disorder. This conclusion is consistent with previous observations (Marttunen, Aro, Henriksson and Lonnqvist, 1992; Shafii, 1989) that completed suicide in adolescents is the termination of long-term difficulties and dysfunction.

The Canterbury Suicide Project researchers concluded that their work suggests that suicidal behaviours are multicausal in origin (Beautrais et al., 1996). Childhood adversity, social disadvantage and psychiatric morbidity make significant contributions, both independently and jointly, to risk of serious suicide attempt in young people. The

Project's approach to date is largely based on the identification of meaningful explanatory factors through use of statistical significance procedures. Such an approach cannot in itself elucidate the actual connections between various explanatory factors, only the extent of correlation between them which may in fact be due to chance (Sayer, 1984). How can we identify causal associations? How are we to understand multicausality? How are the various causes actually related to one another in any particular suicide? The answers to such questions require recourse to theorisations of suicide, explicitly or implicitly. Such theories should help to elucidate the role of explanatory factors and their relationship with others.

Theories which help to elucidate explanations of suicide need to be grounded in empirical research on suicide. Their aim after all is to assist in an understanding of relevant empirical phenomena. On the other hand, empirical studies of suicide, such as those conducted by the Canterbury Project, risk over-emphasising one factor and overlooking the influence of others if they ignore theoretical issues.

However, in the theoretical literature on suicide, many different theoretical accounts are offered. Some theorists have highlighted a range of social and cultural factors. Others emphasise the significance of psychological problems or psychiatric disorders. To some extent, this difference in emphasis reflects the influence of the different disciplinary concerns of sociology, psychology and psychiatry. In

addition, some theories point to the influence of one factor as being crucial. Other theories share the conclusion of the Canterbury Suicide Project and attempt to combine a number of inter-linked factors. Why does this proliferation of theories exist? Does it reflect a theoretical confusion in the contemporary understanding of the causes of suicide? Or does it represent a healthy pluralism arising out of contending theoretical perspectives with different assumptions? Can all the theories be integrated into one overall theory?

Furthermore, to what extent are all the theories addressing the same phenomenon? A depressed man hangs himself. A soldier sacrifices his life by throwing himself on an exploding grenade to save others. A woman dies after climbing out of an overcrowded lifeboat into a freezing ocean, in order to free up a place on the boat for her daughter. In all three cases, death is self-caused, but are all three deaths suicides? Is suicide more than simply killing oneself? For example, how important to the definition of suicide is intentionality? The soldier and the woman did not intend to kill themselves, although they placed their lives in danger. Do their deaths constitute suicides? Or are they examples of different types of suicides? How should suicide be defined? For the Canterbury Suicide Project, coroner verdicts of suicide have been used, an approach which effectively avoids the problem of formulating a satisfactory definition of suicide.

This chapter began with a consideration of the personal response that people like Cathy have to the suicide of a loved one. It then moved on to examine the academic search for explanations of suicide as apparent in the work of the Canterbury Suicide Project. A number of questions have been raised as a result. These fall into five main areas and lead to the formulation of five research questions about suicide and its theorisation which are examined in the rest of the thesis:

1. How should suicide be defined?
2. Why is there a proliferation of theories of suicide?
3. Should this theoretical pluralism be accepted as normal or should theoretical unification be the goal?
4. How are studies of the various explanatory factors of suicide shaped by different disciplinary concerns and the assumptions made by different theoretical perspectives?
5. Is it possible to develop an integrated overall theory of suicide?

Chapter two examines various considerations relevant to defining suicide, including the meaning and social evaluation of suicide in history. A definition of suicide is then offered, comprising of four main elements. Chapter two concludes with a discussion of different typologies of suicide, which illustrate the complexity of the phenomenon but also the different perspectives adopted by typologists. The first half of chapter three addresses the second research question on the reasons for the proliferation of theories of suicide. This leads, in the second half of the chapter, into

a discussion of theoretical pluralism and unification, the subject of the third research question. In chapter four, the main sources of theoretical pluralism are then given attention. These are the subject of the fourth research question: the various explanatory factors as approached within different academic disciplines from different basic theoretical perspectives. Chapter five provides an examination of concepts necessary to answer research question five which explores the possibility and nature of an overall integrated theory of suicide. Chapter six concludes by summarising the findings of the thesis.

CHAPTER II

THE DEFINITION

OF SUICIDE

At first glance, the concept of suicide seems uncontroversial and hardly in need of exploration. Common sense suggests that if someone has taken their own life, then clearly they have committed suicide. If a woman jumps from a high bridge to her death, or a man dies when his depression drives him to shoot himself, surely these would count as suicides.

Upon further considering examples of suicide, it becomes apparent that not all cases are as clear as the two examples above. Consider a soldier who leaps on a grenade to protect others from the blast, or a pilot who chooses to stay with a falling plane to guide it into an unpopulated area - rather than bail out. These cases are also self-willed and the end result is the same as jumping off a bridge or shooting oneself.

It could be argued that the soldier and pilot were offered little or no time to consider carefully their chosen actions, however there are other examples in which time plays no part. Consider those who starve themselves for political causes, or those who refuse medical treatment - even though their lives could be prolonged indefinitely. Some patients may elect to

die rather than continue to suffer or to impose burdens on others.

In some clear cases of euthanasia a terminally ill person may request at some stage through their illness to receive a lethal injection. Other euthanasia cases are more difficult to recognise. For example, care-givers may comply with the request of a patient for a massive dose of morphine while insisting that the intention is to kill the pain. Of course, the expected reality is this will kill the patient due to the morphine slowing respiration (Mayo, 1992).

All of the above examples result in death, although not all suicide attempts do. Some cases result in the person being revived, resuscitated or, for example, taking too small an overdose and regaining consciousness. Suicidal behaviours such as these may or may not mean that the person really intended to die. One point of debate in the literature is whether or not a definition of suicide should focus on the person's will to die, irrespective of whether the attempt is successful or not.

There exists a considerable body of literature which debates how best to tackle the complexity involved in defining suicide. The result is that the explanatory theories that have arisen cannot be assumed to be approaching suicide from a unified definition. For example one of the earliest proposed definitions, developed by Emile Durkheim (1951) stated that, "the term suicide is applied to all cases of

death resulting directly or indirectly from a positive or negative act of the victim himself [herself], which he [she] knows will produce this result" (1951, p. 44). In contrast Jean Baechler (1979) presented a different definition of suicide in which he included unsuccessful attempts. Baechler stated "suicide denotes all behaviour that seeks and finds the solution to an existential problem by making an attempt on the life of the subject" (1979, p. 11). More recently, Edwin Shneidman (1985) has returned to Durkheim's emphasis on intentional action by defining suicide as "a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution" (p. 203).

Any definition of suicide is undoubtedly confronted with the difficulty of trying to include the diversity and complexity of the phenomenon. When considering these definitions it should be acknowledged that our contemporary cultural value system views suicide in a negative light. This may appear to be stating the obvious, but the religious and political ideologies that influence values and attitudes have not always deemed suicide as undesirable. Attitudes towards killing oneself have undergone a series of changes throughout history, resulting in varied social meanings of suicide (Douglas, 1967).

The current undesirable social meaning that is attached to suicide is being challenged once again. This debate is

taking place primarily in the controversial arena of euthanasia. Some advocates for euthanasia argue that it is completely different from suicide, while the critics of euthanasia insist that it is still a form of suicide. Irrespective of this debate, most agree that there are two kinds of euthanasia, passive euthanasia or letting die, and assisted suicide, which is defined as deliberate assistance at a suicide attempt at the request of the attempter (Pritchard, 1995). Since 1990 the Dutch have made it possible to practice both kinds, providing the patient is conscious and a second medical opinion is available (Hellema, 1992).

Other nations and cultures seem to be less comfortable about legalising euthanasia and appear to be caught in a fundamental divide, which sees passive euthanasia as acceptable, and the other as unacceptable. This dilemma is one of rationality. Gillon (1988) referred to the dilemma as a benefit-burden balance, in which the situation calls for a decision as to whether or not a life is worth living. For some theorists the link between the notion of rationality as it applies to euthanasia and those who commit suicide due to their experience of a lack of hope and great psychological pain, is too close for comfort (Pritchard, 1995). Some theorists have simply refused to apply the same arguments to both euthanasia and other forms of suicide. But can the notion of rationality, as an argument in support of euthanasia, also be used to legitimate other forms of suicide (Pritchard, 1995)? A number of theorists reject such an

approach, believing that it enters the realm of moral argument which can only be resolved by society at large (Mayo, 1992).

Further adding to the complexity of the definition of suicide are the religious ideologies and the impact they have had on the social meaning of suicide. For example, the contemporary Christian view that 'thou shalt not kill' includes killing of the self, has not remained consistent through time. The following section gives a brief historical overview of the changes in religious and societal values regarding suicide.

Suicide has occurred at least as long as human beings have kept written accounts of their history (deCatanzaro, 1981). Historical writing from literate early civilisations provides some records of the incidence of suicide and of attitudes toward it (deCatanzaro, 1981). Many of these writings are religious in nature and are more concerned with the ethics of suicide than with accurately portraying its incidence and social ecology (deCatanzaro, 1981).

Suicide appears to have been quite common in Greek and Roman civilisations (Choron, 1972). It was mentioned with some admiration in ancient legends, opposed by Pythagoras and other early philosophers, and actively encouraged by the Cynics, the Stoics, and the Epicureans (Dublin, 1963). Honour suicides (to avoid capture, slavery and murder) appear to have been frequent among the Greeks, the Romans and their neighbours (deCatanzaro, 1981). Farberow (1972) states that

suicide in old age and sickness was also generally acceptable. Suicide by a widow following her husband's death was also not unknown, and often took the form of the widow stabbing herself on her husband's funeral pyre (Rosen, 1971).

deCatanzaro (1981) argued that suicide was rare among the Jews, - there are only six instances cited in the Old Testament, without any accompanying moral judgement. Samson killed himself in the process of killing the Philistines. Saul fell upon his sword after defeat in battle to avoid the ignominy of capture and Saul's armour bearer followed Saul's example. Abimelech killed himself after being mortally wounded by a stone so that his murder would not be attributed to a woman. Atipophael hanged himself when his betrayal of David failed. Zimri burned himself to death following capture of the city in which he was besieged (deCatanzaro, 1981). In the New Testament, the only reported suicide is that of Judus Iscariot, who hanged himself (deCatanzaro, 1981).

For Jews, the social meaning of suicide was that respect should not be paid to the memory of the deceased although the person's family should be comforted (Dublin, 1963). Despite a general infrequency of individual suicides among Jews, there were reportedly some instances of mass suicide, especially when persecution was unusually intense (Dublin, 1963). In 73 A.D., 960 people are said to have killed themselves in the fortress of Masada, when capture by the Romans, with the ensuing slaughter of men, rape of women and

enslavement of children, was inevitable (Dublin, 1963). In 1095 in France, many Jews are said to have killed themselves to escape torture; 500 committed suicide in York in 1190 to escape oppression, while several Jews may have committed suicide in Europe during the plague epidemics of the fourteenth century because they were treated as scapegoats (Dublin, 1963).

Among the early Christians, suicide may have been common, especially in consequence of severe persecution and it may have been viewed quite favourably as martyrdom. By the fourth century St. Augustine categorically rejected suicide because it precluded the possibility of repentance and at the same time violating the Sixth Commandment, Thou shalt not kill. St. Thomas Aquinas elaborated on this view in the thirteenth century, proclaiming suicide to be a mortal sin in that it was a rejection of the goodness of God because it showed a lack of faith in God's power and usurped God's power over life and death (Davidson and Neale, 1990).

Although neither the Old Testament nor the New explicitly forbids suicide, the Western world came to regard it as a crime and a sin (Shneidman, 1973). While the Christian injunction against suicide seemed to be based on a respect for life (in contrast to the Roman view of life), the resulting behaviour was excessive and counter-productive. Those individuals who attempted suicide and the family and friends of those who committed suicide were usually degraded, defamed, tortured and persecuted (Shneidman, 1976).

The Reformation and the establishment of the Protestant Church brought yet another change. Religious values began to emphasise the importance of the individual, especially individual reflection and self-consciousness, and Protestantism equated wealth with virtue and poverty with sin (Shneidman, 1976). As people found themselves not only poor but stigmatised for their poverty, philosophers began to endorse suicide as a legitimate alternative to an unrewarding and unfulfilled life (Shneidman, 1976).

Other cultures frequently discussed suicide in their religious writings also. In India the Brahmins, for example, viewed suicide quite favourably, suggesting that it provided a passport to heaven (Thakur, 1963). Although suicide occurred in a variety of situations, one particularly conspicious form of suicide was suttee, in which a widow would kill herself following the death of her husband (Thakur, 1963). This practice was quite common in parts of the Orient from the time of Alexander the Great, and was frequent until this century (Venkoba Rao, 1975). It varied in character in different times and places. Often the woman would plunge herself into the flames of her husband's funeral pyre, although self-stabbing and other methods may have been more common (Thakur, 1963). The act was often institutionalised, in that pressure or coercion to perform it was exerted by others. It should be noted that only some acts of suttee can be classified as suicide due to some cases being involuntary deaths (Thakur, 1963).

In other parts of the Orient, suicide was also common throughout known history. Suicide was held in high esteem in Buddhist teachings (Dublin, 1963). In China, suicide after defeat in battle, after death of a husband, in insolvency, or in dishonour was viewed favourably (deCatanzaro, 1981). In Japan, suicide may have been fairly widespread (Seward, 1968). The act of hara-kiri was ritualised and institutionalised. It was made compulsory as a form of punishment for those of noble rank, allowing them to die by their own hand rather than at the hand of an executioner (Seward, 1968). Hara-kiri was also frequent as a voluntary act, occurring in despair, dishonour, or other misfortune (Iga and Tatai, 1975).

Even though suicide was considered a valid alternative in many cultures, by the beginning of the nineteenth century the West had adopted a negative social meaning of suicide. Suicide had come to be regarded as a social problem that required an explanation. Although the moral debate about suicide has occurred through the ages, it was not until 1951, with the French sociologist Emile Durkheim, that the first systematic and scientific attempt to define and explain the phenomenon occurred.

Bearing in mind the somewhat variable and dynamic social meaning of suicide and the range of circumstances whereby people commit suicide, it becomes apparent that these issues make defining suicide a far from simple task. Theorists

often wrestle with not only defining a complex term, but a term that to a large extent lacks a precise meaning and is somewhat vague. This vagueness is certainly not isolated to defining only the term suicide. There are many other terms and concepts which prove to be difficult to define exactly, such as a cloud or the wind. Within the literature that debates the nature of definitions, the problem with the notion of vagueness is often examined. The following section discusses two ways the problem of vagueness directly affects a definition of suicide and also suggests a way of conceptualising the moral and social meaning that is attached to suicide.

A definition articulates the meaning of a term and if a term has a precise meaning, a correspondingly precise definition is possible (Reber, 1985). The meaning of terms can be imprecise in any number of ways, however some theorists suggest there are two such ways that have relevance to the definition of suicide.

The first of these occurs when a word that appears in the definition of some other term is vague. For example, a "living person" can be defined as "a person who is not dead". But what "dead" means is not always clear. David Mayo (1992) pointed out that the pressing need for organs has prompted some debate over the definition of "death", especially in such cases where a person has been defined as "brain-dead". Mayo (1992) questions whether or not such people are alive, and if not, why do they receive all that expensive medical

attention in intensive care units? This kind of vagueness is referred to as inherited vagueness, because the term derives or inherits its vagueness from a vague statement of meaning.

The second kind of vagueness relevant to suicide relates to the fact that the applicability of a term depends on some matter of degree. For example, the notion of "wealth" means to have a lot of money, but it is not clear as to exactly how much would make someone wealthy. The same problem occurs with many other terms, such as "cloudy", "lazy", or "young" for example.

Sometimes inherited vagueness and a lack of degree combine, as could be argued with the terms "intention", "intentional" and "intentionally" - a cluster of notions that figure predominantly in the definition of suicide. The term "intentionally", for example, involves matters of degree. A person may do something more or less intentionally (Mayo, 1992). It is reasonable to suggest that a person can in fact have multiple intentions. In many cases some intentions are clearer than others and, as Mayo (1992) states, multiple intentions for an individual can all point in the same direction or to the same course of action. For instance, a person might notice an amazing new car being advertised on television, so goes to the car dealers with the intention of only having a look, but ends up buying the car. It is difficult to determine whether the person was in "two minds" or they went to look at the car with the intention of buying it.

Inherited vagueness is also a difficulty in the use of "intentionally" in defining suicide (Mayo, 1992). Intention entails the notion of seeking to attain an end, of behaving in such a way as to bring something to a close. There is some vagueness about the range of behaviour that will count if the person is to be regarded as an agent in bringing something to a close (Shneidman, 1985; Mayo, 1992). In what way and how directly must one's behaviour be linked to an event before one can be said to end it? For instance, a person may wish to end a friendship. Their course of action may include having an argument with their friend, or being argumentative with significant other people in the friend's life, or spreading a few rumours, or befriending someone else, or simply withdrawing all investment in the relationship, doing nothing and letting the friendship drift apart. It becomes difficult to determine whether some courses of action because of their subtlety are as significant in bringing something to a close.

The following section proposes a workable definition of suicide and attempts to tackle the problems caused by vagueness, but first the social and moral meaning of suicide will be revisited. One way in which the definition of the term suicide is not vague is that it does not actually contain any normative or intrinsic component. Other words such as "cowardice", "racist", or "courage" do contain and carry value judgements as part of their very meaning (Mayo, 1992). By contrast, any value or social judgements that

attach to suicide do not attach to it as part of its meaning. The claims that suicide should be viewed in a negative manner or that suicide is immoral, if they are true at all, Mayo (1992) argues, are not so by virtue of the definition of suicide, but for other reasons, which must be argued independently. Cultural, political and religious ideologies have indeed varied the connotations of suicide through the ages, but this should be distinguished from the indifference of the fundamental definition of suicide - which historically has remained constant.

Turning back to the euthanasia debate, it was mentioned earlier that the social implications of suicide are currently being challenged once again. Some argue euthanasia is acceptable and others claim it is not. Whatever the perspective it is the value judgements that are being challenged not the core definition of the phenomenon (Mayo, 1992). Mayo suggested that because at present anything that can be properly labelled as suicide is to be condemned, those advocating euthanasia feel it necessary to insist as part of their defense that euthanasia is not suicide. In turn, some critics feel that they need do no more to condemn euthanasia than to insist that it is a form of suicide (Mayo, 1992).

Many theorists have suggested that none of this genuinely advances the debate about either the morality of euthanasia or the morality and rationality of suicide. Instead, such discussions run the risk of trading on the general presumption that anything that is suicide ought never be

encouraged (Boldt, 1989). The following section does offer an argument for the inclusion of euthanasia within a definition of suicide. However, the main aim of this section is to propose a workable definition of suicide and discuss the four elements that comprise this definition.

The definition being proposed here is that to commit suicide is to end one's own life intentionally (Reber, 1985). There are four elements to this definition. The first is the fatality of suicide, the second is the reflexivity of suicide, the third is the fact that the agency of suicide can be either active or passive, and the fourth is the intentionality involved.

The fatality of suicide refers to the issue of whether or not the person successfully kills themself. A person may attempt to end his or her life, and fail. Such a person has attempted suicide. Many theorists suggest however, an attempt is not a suicide unless it is successful - that is, unless the attempt ends in death (Mayo, 1992; Shneidman, 1992; Maris, 1992). This requirement is not unique to suicide, but is general and applies to anything one can be said to attempt. Such a distinction should not deny that the study of suicidal behaviour will be equally concerned with both those who successfully commit suicide and those who make nonfatal attempts. Moreover, the field of study also extends to people who do not intend to kill themselves, but engage in suicidal gestures, with the intention of drawing attention to their need for help (Maris, 1992).

The second element of the definition is the reflexivity of suicide. This refers to the concept that for a death to be a suicide, it must be one's own doing. That is, the death was intended by, and then effected by, the person who died (Mayo, 1992). This does not mean, however, that a person must act alone in committing suicide (Maris, 1992). The most straightforward kind of assisted suicide involves a person who has decided to end his or her life but lacks the means to do it alone, and who successfully elicits the assistance of another person by openly sharing his or her intentions (Maris, 1992). In this case the person assisting becomes the agent of the suicidal person, in the sense that he or she acts at that person's request. A case can be described as an assisted suicide regardless of whether the assistance consists only of providing someone with the means or of taking a more aggressive role (Mayo, 1992).

The third element of the definition of suicide is what is referred to as the action-inaction distinction. Committing suicide usually involves suicidal acts. However, as previously discussed, there are cases of people intending their own deaths through appropriate types of inaction such as failure to take life-sustaining treatments. People can commit suicide by either allowing, refraining from getting out of, or suffering situations that will lead to their deaths (Maris, 1992). Mayo (1992) argues that it is a mistake to focus too much upon whether or not a person acts physically, when what is really at issue is what the person's

intentions are in behaving as he or she does. The agency of suicide can either be active or passive.

The final definitional element is the intentionality of suicide. Committing suicide involves intentionally ending one's life. It is this feature that serves to distinguish suicide from accidental self-inflicted death. Although medical examiners recognise this distinction, it is often difficult to distinguish in practice (Douglas, 1980; Mayo, 1992). Douglas (1980) suggests that this difficulty leads to biases in the statistics of suicide. Some occurrences of suicide may not be recorded because of equivocal evidence, attempts to conceal the nature of the act by others or the suicidal person, or unclear definitions of suicide (Douglas, 1980). It is possible that some deaths labelled as suicide may actually be murders or accidents.

Mayo (1992) argued that some deaths labelled as suicides may not be suicides because the person was undertaking a suicidal gesture in which the intention was not to die, but rather to express despair or helplessness. Although death was self-caused in such lethal cases, such persons did not intend to die. Mayo (1992) argued there is a clear conceptual distinction between suicide gestures and sincere suicide attempts, even though distinguishing them in practice can be exceedingly difficult.

Unfortunately, the distinction between genuine suicide attempts and mere suicidal gestures does not spell the end of

either the conceptual or the empirical troubles associated with intentionality. A three-way distinction remains to be drawn among cases. The first is where death is intended as an end in itself, the second is where death is intended as a means to an end and the third is where death is not intended at all, but foreseen as a consequence of what is intended (Mayo, 1992).

With regard to where death is an end in itself, literature suggests that some people may simply decide that they are weary of life and kill themselves because they long for death. They are not suffering and their thinking is not structured around what they will escape by death. Rather, they simply and genuinely wish to be dead and look forward to it - they see death as an end in itself (Mayo, 1992).

The second intentionality distinction refers to cases in which people end their lives not because they find death attractive, but as a means to an end (Shneidman, 1985). Most people who genuinely attempt suicide do so to escape pain (Shneidman, 1985). In these cases suicide means to put an end to suffering that has become unbearable. Although this may be the most typical end suicide serves, it is not the only possible one. People may kill themselves for loftier or much more altruistic ends, such as to spare their families problems, to maintain honour, or to further or express support for a cause (Wood, 1980). Soldiers or spies provided with a quick means for ending their lives, for instance, may use it to kill themselves as a means to avoiding torture

and/or revealing secrets to the enemy (Wood, 1980). People may also kill themselves as a means of impressing or hurting or getting even with others (Shneidman, 1985). In such cases it is argued that death is intended, but as a means to some further end.

The third distinction refers to where death is not intended at all, but is seen as a consequence of the pursuit of ends that people value even more than they value their own lives. People often risk their lives in dramatic ways to save the lives of others. People even pursue life-threatening goals when the loss of their own lives is not merely a risk, but a virtual certainty. A person may climb out of an overcrowded lifeboat into a freezing ocean fully expecting to die, in order to save others in the boat. Although such a person intentionally embarks on a course of action that will lead to death, death is not a direct part of a plan, but an unwanted though unavoidable side effect (Mayo, 1992).

Mayo (1992) argued that these unintended deaths are not suicides, even though the person acts intentionally, and even kill themselves knowingly by acting intentionally as they do, it would be incorrect to say that their intentions are to kill themselves. These cases are not rare and they are problematic because the phrase "she intentionally killed herself" is according to many theorists so crucially ambiguous. Lifeboat martyrs do, after all, kill themselves while acting intentionally.

However, pilots who stay with the falling plane, they do not do so in order that they will die. There is a small chance they will survive the crash without having their intentions thwarted. Similarly, soldiers who leap on grenades and survive the experience, either because the grenade failed to explode or because they survived the blast, suffer no frustration of their goals and hence are not committing suicide (Mayo, 1992). By contrast, for spies who try to kill themselves in order to avoid capture, torture or revealing secrets to the enemy, their deaths are integral components of their plans, and if they do not die their plans go unrealised (Mayo, 1992). Thus they do commit suicide. Whether or not martyrs who starve themselves for a cause are suicides depends upon whether they intend to die for the cause, or whether they are merely risking their lives in the hopes of achieving social change (Mayo, 1992).

The overall discussion on the definition of suicide illustrates how suicide takes many forms which makes defining and classifying problematic. As noted in chapter one, the Canterbury Suicide Project has avoided the difficult conceptual issues surrounding the definition of suicide by defining their sample in relation to coroners' decisions. In doing so, and in not presenting an independently-derived definition, they risk the inclusion of non-suicides and the exclusion of some suicides.

However, a workable definition has been proposed above - to commit suicide is to end one's own life intentionally. It

should not be assumed that such a definition captures every aspect of suicide. What such a definition provides is a useful platform from which to approach the many theories which attempt to explain suicide.

The overall suicidal continuum includes completions, nonfatal attempts, gestures, partial self-destruction, indirect suicide, and ideation (Farberow, 1980). Many theorists argue that these self-destructive acts and thoughts are sufficiently different from one another to require somewhat different explanations or independent predictor variables. Maris (1992) suggests that there are probably at least as many types of suicide as there are explanatory theories of suicide.

Each person who commits suicide has followed a particular pathway in their life course leading up to that moment. Each pathway is a unique combination of experiences, events and vulnerabilities which lead to the development of different psychological and social responses. However, there are different types of suicide which summarise similar individual pathways. Given the diversity of the ways, methods and reasons a person may choose to commit suicide, many researchers have focused their attention on classifying how many types of suicide there are and how they differ. Whereas a definition of suicide attempts to isolate what is common to all suicides, typologies acknowledge and give an account of the diversity of suicides. The following section describes a

substantial body of literature dealing with the typologies of suicide.

Blumenthal and Kupfer (1990) suggest that amongst the varying typologies there may occur some overlap, yet they are each in a way unique. Taking the notion of unique suicides to the extreme, it could be argued that every individual suicide is unique and that no two suicides are the same. Placing the concept of absolute uniqueness within the area of suicide assessment and prediction creates an obvious dilemma for practitioners. Logically, if all suicidal careers were absolutely unique, any one case of completed suicide would have little bearing on the dynamics of any other future suicide. Maris (1992) points out that if this is true, then the prediction of suicide is virtually impossible.

Generally, most suicidologists acknowledge that each suicide is unique in some aspects but not in every aspect. Therefore the notion of absolute uniqueness is usually refuted. Continuing with the assumption that suicides do share some similarities, there is a large body of literature that attempts to group and classify types of suicides. Although there are many proposed typologies, most suicidologists define three or four basic types of completed suicides and two or three subtypes for each basic type (Maris, 1992). The main reason many theorists keep the number of suicide types relatively low is to combat the risk of having a sample size which is too small to analyse meaningfully (Maris, 1992).

However this is not an uncommon empirical concern, especially when researching behaviour that is relatively rare.

The earliest attempts at typologies of suicide consisted mainly of systems derived through sociological theories to explain epidemiological findings or systems formulated through clinical experience to explain clinical observations. Durkheim (1951) explored the sociological roots of suicide and proposed four types (with seven subtypes and six mixed types). The four basic types of suicide were egoistic, altruistic, anomic and fatalistic (Durkheim, 1951). Egoistic and altuistic suicides are polar types, as are anomic and fatalistic suicides.

Egoistic suicide is committed when a person has too few ties to the society and community (Durkheim, 1951). These people feel alienated from others, cut off from the social supports that are important to keep them functioning adaptively as social beings (Durkheim, 1951). Altruistic suicides, by contrast, are viewed by Durkheim as responses to societal demands. Some altruistic suicides, such as the hara-kiri of the Japanese, are literally required as the only honourable recourse in the circumstances.

Anomic suicides may be triggered by a sudden change in a person's relations to society (Durkheim, 1951). A person who experiences severe financial reverses may develop a sense of disorientation, because their normal way of living is no longer possible. Durkheim's fourth type is fatalistic

suicide, which occurs when there is a high degree of social regulation which may lead to an individual becoming choked by oppressive discipline (Durkheim, 1951).

Neuringer (1962) borrowed from and added to categories suggested by several other authors in generating his list of twelve classes of suicidal behaviour. These included psychotic suicide, accidental suicide, suicidal threats and suicidal thoughts, automatisation, chronic suicides, and suicides of neglect and manipulation (Neuringer, 1962).

The American suicidologist Edwin Shneidman has presented several systems of classification, each viewing suicide from a somewhat different angle. Shneidman (1966) has described four orientations toward death: intentioned; subintentioned; contraintentioned and unintentioned. Shneidman (1968) also devised three types of completed suicides: egotic; dyadic and ageneratic.

Egotic suicides result from an intrapsychic debate characterised by what Shneidman saw as a sharply narrowed focus of attention. Other theorists have also commented upon this focussed attention such as, Neuringer (1964) who referred to it as rigid thinking, while Breed in 1972 termed it tunnel vision. This attention focus found in egotic suicides also exhibits self-denigrating depression or in other words, a focus on personal misery to the exclusion of any significant others (Shneidman, 1985). The external environment, employment, health and the like become

secondary; therefore Shneidman argues egotic suicide is essentially psychological not sociological. Shneidman's dyadic and ageneratic suicides on the other hand are essentially sociological. The dyadic suicide's death results from unfilled needs or wishes related to the most important person in the individual's life (Shneidman, 1985). The dyad is that of the suicide and the significant other.

Shneidman (1985) ended up recommending against further attempts at classification as the proliferation of typologies was not proving useful. He also argued that the process of constructing typologies was essentially the forcing of a biological overlay on a psychological event. He suggested instead the explication of the dimensions of suicide as a whole. But as Ellis (1988) and Maris (1992) both pointed out in rebuttal, different types of suicide do exist and need to be specified in the search for explanation. Different types are likely to require different explanations.

To return to the proliferation of typologies: Devries (1968) presented one of the first attempts to define dimensions of suicidal behaviour that would take into account the form of the behaviour (ideation, threat, attempt, or completion), together with the individual's psychological status (disturbed vs. non-disturbed) and presence or absence of prior attempts. This produced a system of ten non-overlapping types (Devries, 1968).

The French social philosopher Jean Baechler (1979) contended that there were four general types of suicide (he also included nonfatal attempts) which he divided into 11 sub-types. The four general types were escapist, aggressive, oblative, and ludic. In all escapist suicides, the central intention is to take leave. Within this category there were three sub-types: flight, to avoid an intolerable situation; grief, to deal with loss; and punishment, to atone for a fault.

Aggressive suicides are directed against another person. They consist of four subtypes, vengeance (to achieve revenge - to provoke a response or to inflict community opprobrium), crime (murder-suicides), blackmail, and finally appeal (to cry for help) (Baechler, 1979).

Baechler's oblative suicides are quite similar to Durkheim's altruistic suicide. There are two subtypes, sacrificial (to gain a greater value than one's own life) and transfigurational (to obtain a heightened state, such as religious martyrdom) (Baechler, 1979).

Finally, ludic suicides are either of two types, the ordeal type (to prove something or to solicit the judgement of others) or the game type (to play with or to risk one's own life) (Baechler, 1979). Farberow (1980) has called ludic suicide and other such behaviour an indirect self-destructive behaviour. Maris (1992) argues that some suicidologists are

doubtful that risk taking should be called suicide at all, since the conscious intention to die is often missing.

Following on from these ideas grew a body of literature basing suicide typologies upon empirical studies. This "second generation" of attempts to classify suicidal behaviour consisted of studies rationally classifying empirical data from samples of suicides or parasuicides (attempted suicides) (Ellis, 1988). Shneidman (1957) derived four types of "suicidal logic" from suicide notes and suggested possible treatment directions for four corresponding types of suicidal persons (surcease, cultural, referred and psychotic). Farberow and McEvoy (1966) studied 43 suicides and 43 deceased, nonsuicidal control cases and described four types. The suicide cases were predominantly classified as "object-loss" and "involutional" types (Farberow and McEvoy, 1966). An "egoistic" type was divided equally between the two groups, whereas a "medical" type was found primarily among nonsuicidal cases.

Hankoff (1979) reviewed information from 151 cases of parasuicide and divided them into three typologies. The first is "stress attempters", who displayed extreme reactions to relatively minor stressors, frequently with anger or hostility. Second, "crisis attempters" where those who had been faced with an acute, seemingly insoluble situation, such as terminal illness in self or a significant other. The third, "disorder attempters", manifested clear-cut psychopathology directly related to the attempt.

Finally, Maris (1981), in discussing his survey data, theorised that suicide has only a few basic types (from two to four), perhaps corresponding to his proposed four "meanings" of suicide ("escape", "aggressive", "self-change" or "self-giving", and "risk-taking"). Maris (1981) suggested that an infinite number of ideal types of suicide could be generated, but that these would for the most part be elaborations on a few basic types.

In addition to the above there has also emerged another manner of approach or "third generation" of research which bases typologies on statistical methods. The most popular has been cluster analysis, a mathematical technique which identifies unitary elements or clusters of closely-associated factors that account for the variability in a data set (Reber, 1985). Colson (1973) used cluster analysis to classify and type 79 graduate students who reported a history of serious suicidal thinking or behaviour and found four "clusters" of reasons for wanting to die. These were "interpersonal loss and loneliness", "health problems", "fear of failure and concern for the future", and "wish to hurt or manipulate another person". In a study of suicide attempters, Kiev (1976) found seven types, ranging from "suicidal gesture" (minimal lethality with low emotional distress) to "acute depressive reaction" (lethal method with minimal probability of rescue). In a post-mortem study, Bagley, Jacobson and Rehin (1976) found three statistically

independent types which they referred to as "depressive", "sociopathic", and "physical illness".

There is a striking lack of agreement between the typologies of suicide. Ellis (1988) has argued that this is predictable, given the wide variation in samples studied, variables analysed and classification methods used. Some studies have examined suicides post-mortem, whereas others have focused on ideation or nonfatal acts. Furthermore, great inconsistency can be seen in types of data collected (demographics, lethality, circumstances surrounding the attempt, personality variables, etc.), with a number of variables ranging from a few to several dozen (Ellis, 1988).

The state of disarray in suicide typologies is not due to a lack of suggested typology frameworks, as such proposed frameworks have appeared with some frequency for over a century. Ellis (1988) likens the lack of agreement between theorists to the proverbial three blind men touching various parts of an elephant and coming up with radically different descriptions of the same animal. In this sense, various proposed typologies of suicidal behaviour may be equally valid and yet inconsistent.

Given the vast range of suicide typologies and suicide theories in general, a pattern or observation emerges that suggests the diversity within suicide theories tends to be biased according to the disciplines of their creators. For example, Durkheim focused on social types, whereas Shneidman

and others have taken a psychological or psychiatric approach. Maris (1992) argues that it is quite understandable that researchers see suicide through their own disciplinary glasses. That is, perspectives on suicide and types of suicides reflect professional training and biases (Maris, 1992).

Most of the literature on suicide reflects the disciplinary biases of sociologists, psychiatrists, or psychologists (Maris, 1992). Clearly, there can be theories based on any of the other disciplines or subdisciplines (Maris, 1992). For example, there are biological, biochemical, genetic, endocrinological, neurotransmitter-based, and other such explanations of suicide These varying disciplines are not necessarily mutually exclusive, but rather tend to focus or place more emphasis on different aspects of a complex phenomenon.

Typologies of suicide identify different kinds of suicides which may require different kinds of explanation. Typologies are therefore significant as part of the explanatory process required in empirical studies. The Canterbury Suicide Project, for example, has not to date dealt with a typology of suicide. This may partly be due to the lack of a clearly-agreed upon typology in the literature. However, without a typology the Project will find it difficult to distinguish clearly between the different types of suicide. This in turn will hamper its ability to provide adequate explanations for the differing types.

The definition of suicide discussed earlier in this chapter describes the basic elements common to all suicides. The various typologies that have just been examined illustrate the great diversity of types of suicide. Together the definition and the typologies reflect a view of the conceptual unity of the phenomenon of suicide as well as its complexity.

The different definitions and different typologies of suicide that exist arise out of the emphases that researchers have placed on different explanatory factors. These in turn have led to the construction of different theories of suicide, the subject of the next chapter.

CHAPTER III

THEORETICAL

PROLIFERATION AND PLURALISM

IN THE THEORIES OF SUICIDE

There is a proliferation of theories apparent in the study of suicide. Many of the theories originate in different fields of knowledge. Furthermore, within each field of knowledge can be found a number of competing, and perhaps complementary, theoretical approaches. The second research question formulated in chapter one asks why there is such a proliferation of theories. The following brief and selective account provides some sense of this theoretical diversity, followed by an examination of the three main sources of proliferation. Research question three asks whether theoretical pluralism should be accepted as normal. The second half of this chapter addresses this issue.

As stated earlier, around the turn of the century, the sociologist Emile Durkheim was the first social scientist to attempt research on suicide in a scientific manner. Durkheim's (1951) fundamental argument was that suicide is a reflection of a disturbed relationship between the individual and the society in which the individual lives.

In 1910, by contrast, Sigmund Freud introduced a completely different argument to account for suicide. It was based upon two major hypotheses dealing with psychological phenomena. The first hypothesis is an extension of his theory of depression and basically views suicide as a form of murder. When a person loses someone whom he or she has ambivalently loved and hated, and introjects that person, aggression is directed inward (Freud, 1967). If these feelings are strong enough, the person will commit suicide. Freud's second major hypothesis postulates that the death instinct, Thanatos, can turn inward and make the person take his or her life (Freud, 1967).

Shneidman (1992) pointed out that, since the pioneering work of Durkheim and Freud, more than 40 different theories have been postulated on the causes of suicide. Some theories focus directly upon suicide, while others deal with it indirectly. The latter theories, for instance, address the broader context of aspects of psychological functioning which are relevant to acts of suicide.

Two theories which approached suicide within the context of broader issues were those of Murray and Pepper. Murray's (1938) personality theory located explanation in relation to a classification of human needs. He argued that the suicidal act can be understood only as an action aimed at meeting certain needs. By contrast, Pepper (1942) contended that suicide is best understood primarily as an existential act of despair. In the face of an inability to answer

satisfactorily existential questions about the meaning of life and life after death, Pepper (1942) suggested that people fall prey to chronic despair and ultimately suicide.

Among those theorists who have approached suicide directly, Henry and Short (1954) draw on the Freudian tradition in their psycho-dynamic focus on aggression and frustration whereas Bunney and Fawcett (1965) promoted another explanatory direction by looking to biochemical imbalances in the body. Henry and Short argued that aggression is often a consequence of frustration. Usually, to release this frustration, an individual will become aggressive towards the frustrating person. However, some children develop and legitimise a self-directed aggression to frustration which can lead to suicide (Henry and Short, 1954). Bunney and Fawcett (1965) claimed that the most important causal factor in suicide is biochemical imbalances in the body fluids, such as in the blood or in the organs such as the brain.

Soon after, Douglas (1967) returned to Durkheim's sociological notion that suicide should be understood in terms of how an individual is estranged or tied to his or her society while Beck (1967) continued on in the more individualist psychological tradition, drawing on a model of depression as an explanatory resource. For Beck, however, a cognitive approach was adopted rather than the neo-Freudian psycho-dynamic approach. Beck argued that depressed people tend to accept personal responsibility for failures and

negative outcomes to such a degree that the self-blame often leads to desires for self-punishment.

Among the most recent theories of suicide, diversity persists. For example, in 1986, Pfeffer proposed a theory relating to suicide being strongly linked to the stressful interactions between two people or within a family nexus. Also in 1986, Roy introduced a theory that placed the cause of suicide at the physiological level. According to him, suicide is an expression of genetic or inborn factors. Lester's (1987) main assertion is that suicide is a learned behaviour with childhood experiences and forces in the environment playing crucial roles.

Research question two in the first chapter asks why there is such a proliferation of theories of suicide. There are perhaps three main sources of proliferation: the complexity of the phenomenon of suicide, the influence of disciplinary approaches, and the existence of a range of different basic theoretical perspectives. These will be dealt with in turn below.

Suicide is a complex phenomenon, consisting of many different types that can only be explained by reference to a multitude of factors. As Maltsberger (1992, p. 26) put it, suicide is a "multiplex phenomenon". Maris (1992, p. 65) referred to the "complexity, variability and multidimensionality" of suicide. We can expect the development of different theories which deal with different types of suicide and with the

significance and influence of different dimensions or factors. In other words, suicide is a domain of study which consists of a number of sub-domains which require their own theoretical explanations. Another level of theory will also arise which examines the interaction between various sub-domains or factors. Levels of theory will be examined further below. As noted at the end of chapter two, there are also a number of different types of suicide. These differ from one another to such an extent that different types of explanation may be required. Such a view reflects Barnes' (1995) contention that murder-suicides are not all the same. She argued that, for example, a murder-suicide involving a father and his children required a different explanation to that involving a husband and his wife. Furthermore, a dozen apparently similar suicides can arise out of a dozen different sets of circumstances (Shneidman, 1989). One of the implications of such variability in suicide types is that no one theory can be comprehensive enough to explain them all.

The second source of the proliferation of theories in the study of suicide is the operation of different disciplinary approaches. Maris (1992, p. 68), for example, lists 12 academic and professional disciplines involved in the study of suicide. Each discipline has its own approach or emphasis reflecting its own training and focus of concern. In relation to understanding the causes of suicide, there are four main disciplinary approaches: biological (primarily biochemical), psychiatric, psychological and sociological.

Each discipline contains sets of theories reflecting its emphasis on different aspects of suicide. Often a discipline consists of a number of sub-disciplines which in turn contain their own theories. One of the most important theoretical challenges facing the study of suicide is the synthesis of the partial views of suicide produced by the different disciplines and sub-disciplines.

The third main source of the proliferation of theories on suicide is the existence of a range of different basic theoretical perspectives. Such perspectives have sometimes been referred to as paradigms (Davidson and Neale, 1990), ideologies (Shames, 1987) and research traditions (Gholson and Barker, 1985). They provide a theorist with an orientation, with a set of principles (more or less systematised) which guide data analysis and theory construction. A basic theoretical perspective often indicates what is the most significant aspect or issue on which a theorist should focus. Such perspectives in psychology include structuralism, functionalism, behaviourism, developmentalism, the cognitive and psychoanalytic approaches, humanism, feminism and, most recently, postmodernism (Gergen, 1992; Gergen, 1993; Stagner, 1988). In other disciplines, similar basic theoretical perspectives can be found along with additional ones. Some of the proliferation of theories of suicide can be attributed to the influence of basic theoretical perspectives.

Another kind of basic theoretical perspective is that concerning the nature of science and the kind of scientific standards applicable to such disciplines as psychology. For example, psychology has been dominated by a positivist view of science which has followed the model of scientific explanation in the physical sciences. The physical science model has assumed that there is a largely static and singular underlying reality which can be described relevantly and unambiguously in a scientific language (Lindholm, 1985). It has given rise to a quest for cause and effect relationships which are seen to be independent of time, space and the consciousness of the researcher and the researched (Galtung, 1977). An empiricist approach to data has been adopted which has led to a preoccupation with quantitative methods. Cause and effect laws or generalisations have been sought within the overall development of theories with hypothetico-deductive structures. The positivist perspective has often resulted in a reductionist account of psychological phenomena. Critiques of the adoption of this view of science in psychology have arisen from a number of quarters, especially humanist and feminist approaches. According to them, psychology should adopt the goals and methods of the human sciences which reject the determinist and reductionist cast of positivism. Realist philosophy of science has been one alternative drawn upon by some (Manicas and Secord, 1983). Such differences in basic theoretical perspectives on the nature of science give rise to different theoretical approaches to phenomena and contribute to the proliferation of theories.

There is debate over how influential basic theoretical perspectives are in scientific study. For example, the notion of paradigm, developed by Kuhn (1962 and 1970), constitutes the view giving the most influence to basic theoretical perspectives. For Kuhn, a paradigm is a disciplinary matrix consisting of a set of basic assumptions specifying the sub-universe of scientific inquiry, the concepts that will be regarded as legitimate and the method that may be used to collect and interpret data. In this view, the meaning or import attributed to data depends to such an extent on the paradigm that different theories about the same phenomenon are taken to be incommensurable when they arise from different paradigms. Incommensurabilty means that empirical comparison cannot determine which theory is correct because, for instance, what is considered to be legitimate data or what is considered to be a valid interpretation of data differs so markedly between the paradigms. Empirical data are theory-laden, if not to a significant degree theory-determined. A number of psychologists have rejected the relevance of such a notion of paradigm and incommensurability to psychology, arguing instead for a weaker influence for basic theoretical perspectives (Gholson and Barker, 1985; Kitchener, 1985; Meehl 1993). In other words, theories reflecting different basic theoretical perspectives may, at least sometimes, be compared on an empirical basis and some of the key principles of different basic theoretical perspectives can be debated in the light of empirical evidence.

Given the proliferation of theories on suicide due to the three main factors discussed above, should we expect there to remain a pluralism of theories or should it be anticipated that a theoretical unification should develop? This then is the third research question to be examined in this thesis and is the subject of the second half of this chapter. The issues just discussed provide a framework for understanding the nature of theoretical pluralism and the possibility of theoretical unification.

Is theoretical pluralism unavoidable? Or is it merely an instrument to employ toward the goal of theoretical unification or monism? Are both perspectives valid? There are two issues that need to be addressed before debating the above questions. The first centres on the developing scientific maturity of psychology while the second concerns the different types of theoretical pluralism.

Many theorists take theoretical pluralism, the absence of theoretical unification, to be a sign of the immaturity of a science such as psychology. This notion of immaturity originates mainly in positivism (Reber, 1985), and has been reinforced by the work of Kuhn (1970). Kuhn argued that a discipline's theoretical pluralism was evidence of its preparadigmatic or protoscientific stage. In a successful science, this prescientific period will give way to a paradigmatic period of real science in a discipline, in which theoretical unification will replace theoretical pluralism.

Basic disagreements concerning theoretical, methodological, and philosophical issues will be resolved and there will be a consensus about these fundamentals (Kitchener, 1985). When this occurs, according to Kuhn, psychology will have become a mature science like physics, astronomy, and biology.

Theorists such as Koch (1974) would go so far as to say that theoretical pluralism has resulted in too much conceptual confusion and too little consensus, which ultimately means that psychology has failed as a scientific endeavour. Other theorists have agreed to a point, but have argued that Koch's abandonment of a scientific psychology altogether is premature. Instead, they advocate that theoretical pluralism constitutes a scientific crisis to be resolved with the aim of achieving theoretical unification.

However, some view theoretical pluralism not as a sign of immaturity or of crisis. After all, they point out, theoretical pluralism does exist within what some refer to as the mature sciences (Royce, 1985). So, is it possible for psychology to be a mature science even when it contains theoretical pluralism? Some theorists have suggested that in order to answer this question, the reasons for a plurality of theories existing simultaneously needs to be more closely examined. The following section contains a consideration of the different types of theoretical pluralism identified in the literature and their relevance to an appreciation of theoretical pluralism in the study of suicide.

Sequential pluralism refers to the way in which, although two theories of suicide may exist at the same time, one is in the process of being discarded in favour of the new and better one. The new theory provides a more accurate account of the empirical data on suicide than the old one. Such a view of sequential pluralism reflects a positivist view of theory. Positivism assumes that a singular static reality exists and that scientific knowledge consists largely of an unproblematic correspondence between data and theory. This is sometimes referred to as naive objectivism (Sayer, 1984). A positivist account of scientific progress is one of sequential pluralism, implying that it is a characteristic of a mature science (Royce, 1985). Realists reject the naive objectivist or correspondence view of science and argue that the notion of resolving competitive theories by empirical study is not as straight forward as it first appears. All data are theory-laden and contextual, and knowledge is always fallible (Sayer, 1984). In this view, the resolution of competing theories of suicide must at least partly depend upon a consideration of presuppositional, conceptual and theoretical issues.

Simultaneous pluralism occurs where one theory is not discarded in favour of the other, that is, where two competitive theories of suicide co-exist for an extensive time. This may be the result of a reluctance to accept or acknowledge the advances contained in the better theory. On the other hand, simultaneous pluralism may arise from the inability of either theory to be clearly better and more

empirically powerful than the other (Royce, 1985). The influence of different basic theoretical perspectives may account for the difficulties of identifying or accepting better theories. The positivists have argued that both types of simultaneous pluralism are characteristic of an immature science (Hyland, 1985). It is assumed that competitive theories of suicide should in fact be resolved by empirical study and that pluralism would give way to unification.

Kuhn (1970) argued that one difficulty of theoretical pluralism within an immature science is that all the empirical facts appear equally relevant. Theorists of suicide have faced the same difficulty. Of all the factors potentially relevant to an explanation of suicide, which are the most relevant? According to Royce (1985), the difficulty of deciding which facts are relevant has resulted in psychology in general adopting a basic strategy of stalling for time, because the development of theories with a high degree of explanatory power is a slow and difficult process which usually requires several generations.

However, a plurality of theories may not really be competitive in that they may not really provide alternative explanations of the same phenomenon. They may instead be complementary. Complementary theories address different sub-domains, such as different types of suicide, as opposed to the whole domain of suicide. Kuhn (1970) has argued that the many theories of an immature science often cover different aspects of the domain in question. That is, most of the

theories are actually complementary even though they appear to be competitive.

For example, within the theories of suicide, Clark and Horton-Deutsh (1992) have emphasised the importance of affective disorders and substance abuse disorders within those who commit suicide. Orbach, Rosenheim and Hary (1987) proposed a theory which argued evidence in favour of suicide as a result of the ineffectiveness of adaptive coping skills, hopelessness, dysfunctional assumptions and dichotomous thinking. Both theories seem to be offering different explanations for suicide, so they appear to be competitive.

These two theories may be addressing different sub-domains of suicide, as opposed to explaining all suicide. Both theories deal with cognitive ability but only one theory deals with psychological disorders. It may be argued that although these theories appear to be competitive, they are in fact complementary. That is, the theory of Orbach, Rosenheim and Hary (1987) is not addressing the same type of suicide as the theory of Clark and Horton-Deutsh.

If the plurality of the theories are complementary, then there arises two possible evaluations of this situation. The first is the positivist evaluation that complementarity is characteristic of the immature sciences and hence by implication is something which should be eventually discarded. This viewpoint suggests that a general theory

should be able to be developed that makes special cases of each of the partial or sub-domain theories (Royce, 1985).

The non-positivist viewpoint held in psychology suggests that scientific explanation of human behaviour should not be modelled on the physical sciences. The quest for a general theory on the physical science model should not be imposed on a different discipline. Such an imposition does not do justice to the diversity of ways of comprehending and conceptualising a phenomenon, that is, to the range of basic theoretical perspectives that exist and may further develop. Lindholm (1985) argued that, ironically, any totalising perspective ends up providing only a partial view and merges into ideology. Thus a general explanatory theory actually contributes to the increasing fragmentation of knowledge. "Fragmentation as ideology is denial of context" (Lindholm, 1985, p. 329).

The non-positivist view suggests that theorists should not seek general explanatory theories but rather conceptual frameworks. Such a viewpoint recognises that social and psychological reality is a complex open system that is deep and multifaceted, with the merging of contradictions and the resolution of paradoxes (Manicas and Secord, 1983). There are distinct limits to the ability of scientific knowledge to explain all aspects of a phenomenon such as suicide. Working towards a conceptual framework instead of one general theory is consistent with the notion that research is guided by basic theoretical perspectives which determine the selection

of topics for research, the selection of methods and the manner in which completed research projects are subjected to evaluation.

So in the positivist view, theoretical pluralism is an immature state, but maturity arises when a general theory in effect unifies the plurality. In the non-positivist view, theoretical pluralism is much more acceptable and reflects the complexity of reality and the limitations of science.

The third research question set out in the first chapter asks whether theoretical pluralism should be accepted as normal or whether theoretical unification should be the goal. In relation to the plurality of theories of suicide, in the light of the above discussion, there are three main points that can be made. First, the oversimplistic notion that there exists a number of competing theories which attempt to explain the same phenomenon, which can ultimately be resolved by empirical study, is rejected. This view implies a positivist understanding of theory which rejects the validity of the influence of basic theoretical perspectives. However, it may very well be that competitive theories of suicide exist within each theoretical perspective and that a number may be discarded in favour of the one which provides the best account of the empirical data on suicide as understood within that theoretical perspective.

Secondly, it is acknowledged that the theoretical pluralism within suicidology partly arises out of the existence of

complementary theories which deal with different sub-domains of suicide. In other words, different theories deal with different types of suicide or with different factors which lead to people committing suicide. Of course, very often theorists are at least partly guided towards the study of certain sub-domains by their disciplinary or sub-disciplinary training or by their basic theoretical perspective. The pluralism arising out of this set of complementary theories reflects real differences in what is required to understand the different sub-domains. A theory which explains one type of suicide may not be adequate in explaining another. For this reason this kind of theoretical pluralism is positive. Some theorists argue that a general theory of suicide should be sought, one which encompasses all types of suicides. It is later argued that such a general theory can exist only at an abstract level and will lack strong explanatory power.

Thirdly, as already noted above, different basic theoretical commitments underlie much of the theoretical pluralism in the study of suicide. These give rise to competing theories which may be giving accounts of the same sub-domain or phenomenon but which may not share the same understanding of what makes a good theory and which methodological principles are assumed to be valid.

In some cases, two basic theoretical perspectives may actually be so different from one another that they may approach the characteristics of Kuhn's (1970) paradigms (disciplinary matrices) and be at least partly

incommensurable. For example, the more critical and holistic perspectives, including humanism and feminism, are significantly different from the more reductionist and determinist perspectives such as classical behaviourism. As Gholson and Barker (1985) demonstrated, the differences between the cognitive and contemporary behavioural perspectives are much less significant.

Kuhn (1970) referred to the duck-rabbit figure as a perceptual demonstration of the point concerning incommensurability. The point is that when there are no loci where the two percepts overlap, a person either sees a duck or a rabbit for varying periods of time, but never some combination of the two. Such psychological constructs as concepts, symbols, styles and values constitute a contextual backdrop from which perception is conceived. This means, that one's world view and philosophy of life are also part of perceptual processing. The major implication of the principle of incommensurability in the context of theoretical pluralism is that there is no way to translate fully between theories that are generated from different paradigms, thereby involving different presuppositions, methods, and exemplars (Kuhn, 1970).

In the case of two or more highly plausible paradigms existing at the same time, in order to understand the world view of each paradigm, the theorist must make a gestalt switch from one to another. However, if the plurality of theories arises from a plurality of paradigms, theoretical

unification can only arise upon the resolution of competing paradigms. Kuhn (1970) referred to this kind of change as revolutionary science. The revolution involves a change in all aspects, all the way from the underlying philosophical assumptions to the observed facts.

Theoretical unification in this case actually occurs as a result not only of scientific activity, but also sociological and ideological processes within the scientific community (Kuhn, 1970). Theoretical unification of incommensurable theories is possible only if everyone can be convinced to adopt and work from the same paradigm.

Some theorists live with a tension between acknowledging the legitimacy of different basic theoretical perspectives and wishing to hold on to the ideal of some form of theoretical unification. In some ways, this appears to be giving in to radical relativism, that is, it implies that each approach is as truthful or valid as another. Royce (1985) has argued that this results in mental paralysis, due to the lack of ability to ground or base a critique on the theories.

However, such mental paralysis need not be the outcome, if relativism is not assumed to imply a lack of commitment (Paterson, 1984). It is possible for theorists to make a critical (reflexive) commitment to that theoretical perspective which is in accordance with their own personal views of reality but in the spirit of tolerance to give room to other perspectives which have their own different

commitments (Paterson, 1984). This should not be seen to discourage inter-perspective debate but rather to encourage it.

Two key arguments have emerged in support of the value of some form of theoretical pluralism: first, the recognition that different types of suicide, and the role of different factors which lead to suicide, may require different theoretical explanations; and secondly, acknowledgement of different basic theoretical perspectives within academic disciplines. In the next chapter, research question four is examined: how are studies of the various explanatory factors of suicide shaped by different disciplinary concerns and the assumptions made by different theoretical perspectives? The different factors that have been considered to be important in explaining suicide are discussed within a framework based upon four main disciplines, and the influence of basic theoretical perspectives on the understanding of these factors is noted.

CHAPTER IV

EXPLANATORY FACTORS, DISCIPLINARY FOCI AND THEORETICAL PERSPECTIVES

Almost every theorist of suicide has acknowledged that there is a wide range of factors relevant to an understanding of suicide (Maris, 1992). However, most go on to deal with only a small number of those factors in detail. The factors that a theorist focuses on depends on the theorist's discipline or sub-discipline as well as upon the basic theoretical perspective. The following discussion of the various explanatory factors of suicide is structured in relation to the four main disciplinary frameworks that have dominated the theoretical literature on suicide: biological, psychiatric, psychological and sociological.

In biology, there have been two main approaches in the study of the causes of suicide, the biochemical and the genetic. Contemporary biochemical studies began in the 1950s when it was observed there was a chemical similarity between the putative neurotansmitter serotonin and LSD. This led to the suggestion that schizophrenia might be caused by abnormal serotonin transmission. In the 1960s, it was recognised that the use of reserpine (which depletes brain stores of serotonin, noradrenaline and dopamine) could cause severe

depression in some cases. At about the same time, pharmacologists discovered that monoamine oxidase inhibitors (MAOIs) and tricyclic compounds of the imipramine type (called antidepressants) also interfered with turnover of the monoamines in the central nervous system.

These observations led to two hypotheses which were primarily about depression. The two hypotheses were referred to as the noradrenalin hypothesis and the serotonin hypothesis, both of which stated a relationship between depression and transmission at certain key sites in the central nervous system.

More recently, two clusters of biological factors that tend to correlate with suicidal behaviour have emerged. The first is variables associated with a serotonergic transmitter or more specifically the monoamine serotonin, 5 hydroxy-tryptamine (5-HT). The second area where research has focussed is in relation to certain endocrine functions, particularly the release of cortisol and thyrotropin. Asberg (1986) stated that in the period 1958 to 1967 there were only five among 1,267 titles on the general topic of suicide that dealt with biological subjects. In 1986 there were 152 references, mostly on biological aspects of depression and suicide (Asberg, 1986).

Suicidal behaviours, violence and aggression have been found to be related to 5-HT levels in both humans and animals, but it is not clear whether this is a state or a trait, that is,

a cause of such behaviour or produced as a result of (or associated with) such behaviour. For instance, the relevance of low levels of 5-HT becomes clearer when considering this in comparison with life-time suicide trends. It has been observed that the incidence of suicide is very low in preadolescent children (Pfeffer, 1985). The suicide rate then begins a steep rise in early adolescence, reaches a peak in late adolescence, where it then plateaus or rises slightly during adult life until approximately age 65, at which time it begins another dramatic rise (Blumenthal and Kupfer, 1990). It has been shown from within-group studies in late adolescence, middle adult life and the elderly that as cerbrospinal fluid (CSF) 5-hydroxyindoleacetic acid (5-HIAA) and (5-HT) levels decline, the suicide rate for these groups rise.

Some data indicate that a number of conditions associated with glucose metabolism, corticosteroid metabolism, 5-HT metabolism, or neurological disorders may make direct contributions to suicidal behaviours. Such glucose metabolic conditions include, diabetes or insulin secretion disturbances (Linnoila, Virkkunen, Roy and Potter, 1990). Cortiscosteroid metabolic conditions include, Cushing's disease or a major disturbance in cortisol metabolism (Lewis and Smith, 1983). An example of 5-HT metabolic disturbances include, carcinoid syndrome and Lesch-Nyhan syndrome (Castells, Chakrabarti, Winsberg, Hurwic, Perel and Nyhan, 1979). Neurological conditions (which may also include disturbances in 5-HT metabolism) include disorders such as

epilepsy, Parkinson's disease, Cornelia de Lange syndrome and Gilles de la Tourette syndrome (Cohen, Shaywitz, Caparulo, Young and Bowers, 1978).

The extent to which aggressive and suicidal behaviours may be attributed to family instability versus biological variables is important for both pathological and therapeutic considerations. Brown, Goyer, Lamparski, Linnoila and Goodwin (1988) investigated 36 inpatient military men from whom aggression ratings, suicidal history, CSF 5-HIAA, and histories of eight factors thought to be related to family instability were available. Results indicated that those whose mean rating of aggressive history was above a normal range had a significantly higher frequency of suicide attempts, lower levels of CSF 5-HIAA, and higher family instability scores. Furthermore, those with a history of suicide attempts had significantly higher aggression ratings, lower levels of CSF 5-HIAA, and higher family instability scores. In addition, those with CSF 5-HIAA levels below the median had significantly higher aggression ratings and a higher frequency of suicide attempts, but did not show a significant difference in family instability scores. Thus, the authors concluded decreased CSF 5-HIAA is not necessarily associated with increased family instability, but is associated with an increased likelihood of aggressive and suicidal behaviours. Those individuals who are aggressive or suicidal usually do come from more unstable families. Low CSF 5-HIAA or family instability alone may not necessarily predispose an individual toward aggressive or suicidal

behaviours, but if both are present, the individual is considerably more at risk of evincing those behaviours (Brown et al., 1988).

In the genetic line of approach in biology, contemporary theorists have proposed five lines of evidence that it is argued support the notion that certain genetic factors can be found within those who commit suicide. This evidence stems from clinical studies, twin studies, the Iowa-500 study, a study of the Amish and the Copenhagen adoption studies. This collection of studies showed 5% to 15% of suicides have suicides among first-degree relatives (Roy, 1992). On average, 13% of twins are concordant for suicide; usually they are monozygotic twins (Roy, Segal, Centerwall and Robinette, 1990).

Of Amish suicides, 20-24% had a history of affective disorder (discussed further in the psychiatric paradigm) among first-degree relatives and no suicides (Egeland and Sussex, 1985). Of 57 adoptees who committed suicide in Denmark, a statistically significant number had biological relatives who committed suicide, but almost none of the adoptee controls did (Wender, Kety, Rosenthal and Schulsinger, 1986). Many theorists working from this paradigm have suggested that this Copenhagen adoption study provides the strongest and most compelling evidence that there is a genetic component affecting suicide.

One criticism that the genetic and biochemical studies in biology face is that their conclusions rest mostly on statistical differences between suicidal and non-suicidal individuals. It is important to note that, as of yet, it has not been discovered what exactly is being transmitted. Many opposing theorists are not convinced that it has been effectively demonstrated, for example, that manic-depression and alcoholism are genetically transmitted. This implies that the assumption that suicide is also genetically inherent is suspect. It is suggested one weakness with the genetic approach is that the conceptualisations and the evidence in this matter are murky and eqivocal.

There are now many studies of different chemicals and different methods involving enormous energy and thought, dozens of investigations and hundreds of subjects. Another criticism of those who focus on the biochemical aspects of suicide is that it is useful to distinguish the task of explaining suicide from the task of explaining depression, or for that matter schizophrenia and alcoholism. Many theorists have argued that suicide and depression are not synonymous. Although there is currently much research and development on depression, Shneidman (1989) cautions that although it is an important goal to try to cure all depression, this in itself would not eliminate all suicides.

It is important to recognise that the various studies of biochemical factors relevant to suicide are focusing on only one aspect of human functioning. A number of scholars have

noted that there are distinctly different aspects or levels to human functioning. For example, the realist philosopher, Bhaskar (1979), refers to the three ontological levels of neurophysiological (biochemical), psychological and social. He argued that these three levels are irreducible to one another even though there are important ways in which they are linked (Sayer, 1984). As Manicas and Secord (1983, p. 402) noted, a "lower-order domain" provides the basis for the existence of some "higher-order attribute" - "for example, our speech apparatus is the basis for the power of speech". The implication is that events and processes at the biochemical level are necessary for psychological functioning to occur but that psychological functioning is not reducible to these biochemical phenomena. There is a qualitative difference between the biochemical and the psychological such that they ought to be studied in their own right and that attempts to make direct causal links between them tend to fail.

The second discipline significantly involved in the study of explanatory factors in suicide is psychiatry. Psychiatry is a medical specialisation which, although it focuses on the biochemical aspects of mental illnesses, has developed historically as a distinctive academic and professional discipline (Reber, 1985). The psychiatric literature contains a formidable and overwhelming number of studies which have led to some interesting discoveries. It appears that people with mental disorders engage in suicidal behaviours more often than the general public, and this

finding holds both for completed and attempted groups. The increased likelihood of suicide in people with mental disorders is significant when all causes of death are considered, and is estimated at approximately five times that of the general population in the several years after an episode of mental health contact (Clark and Horton-Deutsch, 1992).

Generally, the affective disorders or mood disorders are the ones thought to be most often associated with the highest rate of suicide, followed by schizophrenia. There are several subgroups within affective disorders which can be ranked as follows. Unipolar depression has a higher suicide rate than bipolar depression (Modestin and Kopp, 1988), and psychotic depressives have a higher rate than neurotic depressives (Brent, Kupfer, Bromet, and Dew, 1988). It is important to note that a distinction should be made between depression as a symptom and depression as a disorder or disease. Confusion about this overlap has made it difficult for psychiatric studies to reach definite conclusions about the association between suicidal behaviours and these disorders. Despite these difficulties, psychiatric theorists have argued that psychological autopsy studies consistently find that affective disorders are the most important diagnoses related to suicide (Jamison, 1986).

Even though bipolar depression and neurotic depression suicide rates are slightly lower, all the affective disorders have higher suicide rates than schizophrenia. Within the

schizophrenia category those at most risk are young men. Depression and hopelessness are important factors in the suicide of those with schizophrenia. Whether this mood state is part of the illness process or a secondary depression occurring as an adaptation to the illness is not known. It is disturbing but important to note that for this group, there are some studies that suggest complications with antipsychotic medications are partially responsible for the high suicide rate (Drake and Ehrlich, 1985; Perris, Beskow, and Jacobsson, 1980).

Substance abuse disorders have been found in 47% of people with mental disorders (Helzer and Przybeck, 1988). Substance abuse disorder is especially found in those with depression also, and is considered to increase the likelihood of suicidal behaviour. Those with anxiety disorders and depression, also exhibit a higher suicide rate than the general population, although some have argued this is still the case with anxiety disorders in the absence of depression (Sims, 1984). However, one anxiety group differs as those diagnosed with obsessive-compulsive disorders seldom commit suicide (Coryell, Noyes and House, 1986).

A review of 33 studies concluded that 1.5% of patients with eating disorders committed suicide, and that 18-29% of overall mortality could be attributed to suicide (Gardner and Rich, 1988). The importance of these figures is hard to assess, because most of the patients in the studies were

young and it is known that suicide already accounts for a large proportion of mortality in this age group.

With regard to which disorders have higher suicide attempts than completions, as a general rule, personality disorders are linked to nonfatal suicidal behaviours rather than to suicide. In samples of suicide attempters, depressive disorders (such as dysthymic disorders), personality disorders and substance abuse appear most frequently (Tanney, 1992).

The psychiatric approach to the understanding of suicide is confronted with a similar critique to the biochemical approach. The diagnosis of a mental disorder alone is not a sufficient explanation for suicidal behaviour. Not everyone who has a psychiatric disorder will commit suicide. Shneidman (1989) has argued that it is not possible to die of unipolar depression or schizophrenia, whereas it is possible to die from suicide. Many psychiatric theorists have attempted to address this point by suggesting that a psychiatric disorder increases the likelihood of suicide, but that this does not mean suicide will occur. One problematic area of research within psychiatry is finding this actual link between a psychiatric disorder and suicide. Perhaps this link cannot be identified and the notion that it exists reflects a reductionist approach (Bhaskar, 1979). In other words, the different ontological levels may not have been conceptualised clearly enough by psychiatry at this point. Bhasker (1979), for example, argued that the psychological

level cannot be explained fully in terms of the biochemical level. Mental events are of a different order than biochemical events - they are emergent from them and thus closely related to them but complete physical cause-and-effect chains cannot be constructed to link both levels satisfactorily.

The third set of disciplinary studies of suicide, those undertaken by psychologists, emphasises general psychological factors which are deemed to be necessary for a suicide to occur. Different basic theoretical perspectives often identify similar factors of importance although they tend to interpret the factor in different ways. For example, four factors in particular have been highlighted as significant overall. The first is acute perturbation, that is, an increase in the individual's state of general upset. The second is heightened hostility, an increase in self-hate, shame, guilt, self-blame and overtly engaging in behaviours which are against one's best interest. The third is the cognitive state constriction, which is recognised as a sharp and almost sudden tunnelling of thought processes, a narrowing of the mind's content. This typically involves a truncation of the capacity to see viable options which would ordinarily present themselves in the mind. Finally, the fourth is the idea of cessation, the insight that it is possible to put an end to suffering by stopping the unbearable flow of consciousness. The last is considered to be the igniting element that explodes the mixture of the previous three components (Shneidman, 1989).

The second factor, heightened hostility, is of significance, for example, to both the psychoanalytic and cognitive theoretical perspectives. However, this factor is understood in quite a different way from each viewpoint. From the psychoanalytic point of view, suicide is disguised murder of introjected objects (Menninger, 1938). Heightened hostility is thus taken to have originally been directed to an external object such as a father, mother, lover or spouse. This has then been turned against the self. From the cognitive perspective, however, a negative bias in cognitive processing is seen to be significant. It is cognitive processes and their disruption that become the focus. With almost all of the psychological factors discussed below, different basic theoretical perspectives have placed different weightings on some as opposed to others or have understood the origin and meaning of the factors in different ways.

Within psychology, suicide is understood not as a movement toward death or cessation but rather as an escape from intolerable emotional pain (Shneidman, 1989). Different basic theoretical perspectives approach the source and meaning of this differently. However, the overall assumption that the suicide serves as a way of dealing with intense psychological pain, or metapain, still remains constant (Maris, 1992).

Many psychological theorists have agreed that the ability to cope with stressful life events and losses, particularly

during critical periods of the life cycle, is a major factor in the development of coping and adaptional skills in general. Conversely, it is contended that the absence of this ability is an important factor in vulnerability to suicidal behaviour. The literature suggests that continued success in such coping behaviour may lead to a sense of mastery, to a positive attitude toward life and to a sense that life is worthwhile (Yufit, 1988). The lack of the capacity to cope and to adapt can create doubt as to whether life is really worthwhile, or even possible (Yufit, 1988).

The notion of coping and adapting to change has generated much research and focuses around four general concepts. First is the notion that psychological equilibrium consists of adequate coping skills, which predominate over a vulnerability to stress (Neuringer, 1974). Many theorists have suggested that a rigid cognitive style, which an individual has developed over the years in dealing with different life experiences, is one of the major deterrents to not being able to develop suitable new options for problem solving. Some have suggested that when an inability to develop such viable coping options is combined with a loss of hope, diminished internal resources and weakened ego defenses, coping behaviour is often diminished and a sense of vulnerability may become overwhelming (Neuringer, 1974).

The second concept is a negative time equilibrium which arises from a fear of the future plus nostalgia for the past (Shneidman, 1985). This refers to the idea that many people

in times of heavy stress or after sudden loss, experience brief and transient suicidal thoughts. However, with an individual who is coping, these thoughts will typically be displaced by more adaptive options and solutions. When a lack of confidence or a lack of resiliency prevents such shifts in adaption, "a permanent way out" may seem a plausible solution (Farber, 1968). Often found in conjunction with this lack of resiliency are two further factors. One is a tendency to lack a sense of connectedness to belonging (Yufit, 1977), and the other is a perceived empty future which hinders coping with the present (Yufit and Bongar, 1992).

The third concept, suggests that a positive time equilibrium is a function of planned future time orientation and acceptance and integration of past time events. This refers to a plausible, meaningful connection to past, present and future time periods which enhances the coping strengths of a person under more-than-usual stress. Being able to shift to the past in recalling previous methods of successful problem resolution, or to shift to the future in anticipation of an ego-enhancing event, provides an important inner resource or perspective in coping with problems (Antonovsky, 1981).

The fourth concept refers to maintaining a vital balance via resilient and buoyant coping abilities which dominate over vulnerability and loss of a future time perspective. This idea assumes that the loss of meaning and perspective in life can narrow the possibilities for the development of

alternative solutions and may in due time reduce or curtail the desire to live (Yufit and Bongar, 1992). Loss of meaning may increase the possibility of self-harm or self-destruction.

The emotion of hopelessness has also been the subject of much research and has been found to be more strongly related to suicide intent than is depression (Beck, Brown, Berchick, Stewart & Steer 1990). Hopelessness may be defined as a potentially recurring state of negative expectancies (Reber, 1985). Negative expectations related to the development of a suicidal mindset have been shown to include dysfunctional assumptions, dichotomous thinking, problem-solving deficits and a view of suicide as a desirable solution to life problems (Beck, Brown, Berchick, Stewart & Steer 1990).

Although suicides and depressive illnesses tend to run in families, it is unclear whether the cause is genetic or derives from a modelling influence. General conclusions may be drawn however, regarding the effects of the media on suicide rates. The more publicity a suicide receives, the greater the suicide rate (within that geographic area) with teenagers being the most influenced (Phillips, Lesyna and Paight, 1992). It has been observed that the suicide rate is higher for nonfictional stories than for fictional suicides depicted in the media. On average, the modelling effect will be stronger if the message is clear, repeated, on the front page and the copier can identify with the messenger (Phillips, Lesyna and Paight, 1992).

Another research area that has experienced increased attention is the examination of ideation. It has been estimated that as many as 75 to 80% of all suicides have given presuicidal clues of their intentions (Shneidman, 1992). The literature suggests attention should be paid to new wills, new or altered life insurance policies, giving away valued possessions, death or suicide talk, and the like. Many theorists have argued that the usefulness of personal documents have a significant place in social science. Perhaps the most personal document of all is the suicide note. Leenaars (1992) has suggested, the note is the unsolicited communication of a suicidal person, usually written minutes before the suicidal death. One difficulty this form of investigation faces is that what was in the suicidal person's mind and what they wrote may be quite different. In addition only 12-15% of suicide completers actually leave notes (Leenaars, 1992). Despite these difficulties, many have argued that it is an invaluable starting point for comprehending suicide.

Overall, the psychological literature on suicide is also confronted with the same critique as the first two disciplinary approaches. No one has ever died of intense emotional pain. The actual link between suicide and psychological pain and feeling overwhelmed is once again absent. Whether a cause and effect link exists in the positivist sense should be questioned. However, intense

emotional pain remains a significant factor at the psychological level.

The fourth discipline that has been significant in studying the explanatory factors relevant to suicide is sociology. Sociological studies have been primarily concerned with an individual's relationship to others and the social context in which they live. Different basic theoretical perspectives in sociology place different emphases on a range of issues, such as individuals as opposed to social structures. The following account focuses upon the main findings coming from a variety of perspectives.

Emile Durkheim's theory (1951) demonstrated the power of the sociological approach. As a result of his analysis of European data on suicide, Durkheim's typologies emphasised the strengths and weaknesses of a person's relationships or ties to society.

Studies of family development in the sociological literature (as well as in psychology) have suggested that certain kinds of family pathology are related to subsequent suicide as an adult (Shneidman, 1971). Studies of families of suicidal children have found that the family is often disorganised by parental separation, divorce, and stresses of living in a one-parent family (Pfeffer, 1986). The suicidal children were usually distinguishable from other children by the seriousness of family stresses, parental violence and sexual abusive patterns (Pfeffer, 1986).

Physical illness and alcoholism also seem to be apparent in many who commit suicide. Such illnesses can affect a person's ties to society. Studies have shown that about 35-40% of all suicides have some significant physical illness (de Catanzaro, 1992). Diseases that have been found to be especially related to suicide include epilepsy, malignant neoplasms, gastrointestinal problems and musculoskeletal disorders such as arthritis. In a large series of studies of alcoholics, Roy and Linnoila (1986) found that on average 18% of all alcoholics eventually commit suicide. In Robin's (1981) St. Louis research, 72% of completed suicides were either depressed (47%) or alcoholic (25%). No other single predictor was present in more than 5% of the suicides (Robin, 1981).

Alcoholism is more prevalent among certain occupations, and this prevalence influences the suicide rates of these occupations. Male physicians and bar-tenders are an example of this group (Roy and Linnoila, 1986). Also some studies have found an association with occupational stress and downward shifts in the economy increase alcoholism (Herold and Conlon, 1981; Layne and Whitehead, 1985).

There have been a number of studies that have shown a statistical linkage between unemployment and suicide (Adams, 1981; Marshall, 1981; Wasserman, 1983). It has been suggested that unemployment triggers certain social processes that increase the likelihood of suicide for individuals with

high levels of psychiatric morbidity. Two social groups have been identified as significantly affected by increased unemployment. The first group is older, nonretired male workers, who have difficulty obtaining employment during periods of economic downturns (Dooley, Catalano, Rook and Serxner, 1989). The second group is women who may suffer increased family abuse as a result of increased use of alcohol by unemployed partners (Counts, 1987).

With regard to the causal linkage of occupation and suicide, there are many factors that may influence occupational suicide patterns. Occupational suicide is related to exogenous conditions, such as economic depressions or recessions. Suicide rates have been found to increase during such changing social conditions (Araki and Murata, 1987; Stallones, 1990). The opportunity structure also influences the suicide patterns of different occupational groups. Access to the means of self-destruction influences the probability of suicide for various occupations. For example, the highest suicide rate is to be found in medical personnel and is partially related to their greater access to drugs (Rimpela, 1989). There is also an elevated suicide rate for dentists, veterinarians, dental technicians, all of whom have access to drugs that are often used to commit suicide (Milham, 1983).

Internal occupational stress may also influence occupational suicide patterns (Hilliard-Lysen and Riemer, 1988). With regard to physician suicide, there is strong empirical

evidence women physicians have a significantly higher suicide rate than the general female population (Pitts, Schuller, Rich and Pitts, 1979).

Studies in the sociological literature have also focussed on the relationship between marriage and suicide. It has been observed that individuals who are married and have a family have the lowest suicide rate (Smith, Mercy and Conn, 1988). Among white males, suicide rates tend to be highest for the widowed, followed by the divorced, single and married (Smith, Mercy and Conn, 1988). This tends to be true for white women as well. The part played by marital status in suicide is mediated through status integration theory (Stack, 1992). That is, less frequently occupied statuses and those with more role conflict tend to have higher suicide rates.

Classical religion and suicide studies (e.g., Durkheim, 1951) found that Catholics tended to have lower suicide rates than Protestants. However, more recent normative changes among Catholics have lessened, or even reversed, Catholic and Protestant suicide rate differences. Pescosolido and Georgianna's (1989) work has shifted the focus to network ties. Most other religion studies have examined the degree of religiosity rather than simple religious membership because the latter need not correlate closely with significant intervening variables such as religious belief and attitudes.

As long as social interaction is not negative, social involvement of all sorts reduces suicide potential; in other words, social isolation or living alone increases the risk of suicide (Bonner, 1992). For example, in one study of suicidal depressives versus nonsuicidal depressives, 42% of the suicides lived alone as opposed to only 7% of the nonsuicidal depressives (Maris, 1981). It should also be noted that suicide is the leading cause of death in jails and hospitals and it often occurs in large part because an inmate or patient is isolated from other people in the institution (Litman, 1992).

Many theorists have argued that prior suicide attempts must be considered as a substantial risk factor. About 15% of nonfatal suicide attempters will die by suicide (Maris, 1992). However, among older white males (who have the highest suicide rate) that attempt suicide, almost 90% die the first time, typically because they shoot themselves in the head (McIntosh, 1992).

In summary, different disciplines study different ontological levels relevant to an understanding of suicide. Within disciplines, there are usually a number of different basic theoretical perspectives which emphasise different factors or understanding of factors. One of the main challenges facing suicide studies is to resist the fragmentation of disciplines, theoretical perspectives, reductionisms and over-emphasised factors in order to grasp suicide as a holistic phenomenon. This brings us to the fifth research

question formulated in chapter one: is it possible to develop an integrated overall theory of suicide? In order to examine this question, it is important to consider the different levels of theory. The discussion of this in the next chapter begins with an examination of different types of causal factors.

CHAPTER V

DISTAL AND PROXIMAL FACTORS AND DIFFERENT LEVELS OF THEORY

In order to make more sense of the various explanatory factors relevant to suicide, it is useful to consider the notions of distal and proximal (Alessi, 1992; Reber, 1985; Ward and Hudson, in press). This distinction is also useful in the consideration of different levels of theory. Ward and Hudson (in press) present distal and proximal factors as opposites of a continuum. Identifying whether a causal factor is distal or proximal is therefore essentially a matter of degree. Distal factors constitute predispositional or vulnerability causal factors. Developmental experiences and genetic inheritance are considered to be the primary source from which distal factors originate. The role of distal causal factors identifies relevant learning or genetic processes, from which a theory then attempts to identify their psychological consequences.

Proximal causal factors may be defined as the actual triggering event or triggering process. Proximal factors emerge from the existence and functioning of vulnerability factors, such as emotional and psychological states that have arisen primarily from the distal causal factors. In addition

to psychological states, contextual factors, such as the death of a loved one, current life stressors or alcohol and drug abuse may also serve as the igniting element or trigger for, for example, suicide.

Following Ward and Hudson (in press), an example is developed to illustrate the nature and relationship between distal and proximal factors in suicide. In early childhood, an individual experiences a significant loss or may be sexually abused. It may also be that there is a family history of depression. As a result of these distal factors, the individual develops an ineffective coping style, that is, one that is not versatile or flexible. Consequently, there is an inability to adapt to varying stressful life events which may be encountered. A continued ineffective coping style and lowered problem solving ability may result in a lack of emotional buoyancy and resiliency. These are distal factors, although further along the continuum towards proximal factors, as they lead to a vulnerability to emotional consequences such as a loss of inner self-trust, a loss of confidence and lowered self-esteem. There also occurs an erosion of hope for the future, possibly depression, and the loss of a sense of significance and meaning in life. These more proximal factors are internal psychological states which are emotional consequences of vulnerability. Adverse life stressors such as job loss, relationship failure, legal and financial concerns, and drug and alcohol abuse, are all proximal factors which may act as triggers to the individual's resort to suicide.

One of the weaknesses of the research conducted by the Canterbury Suicide Project to date is the lack of conceptualisation of different causal factors. The points made so far in this chapter offer one way in which the Project can clarify the meaning and role of the factors they investigate.

The distinction between distal and proximal factors is also useful in considering the different levels of theory that are involved in the understanding of suicide. Ward and Hudson (in press) refer to four different levels of theory: micro, middle, comprehensive, and global. These will be discussed in turn, with a major digression when comprehensive theories are considered in order to examine Shneidman's (1985) work.

Micro-level theories are qualitative descriptive accounts of causal chains largely focusing on proximal causal factors. These micromodels usually specify the cognitive, behavioural, motivational and social factors associated with the phenomenon. The theories are fine-grained in nature and are easily applied to individual, specific cases.

Middle level theories aim to explain the influence of single causal factors. These theories attempt to depict the structures and processes by which such a factor has its effect, and tend to focus more on distal factors. Each of these single factor theories tends to centre around a core construct, such as social structure or abnormal problem

solving. Ward and Hudson (in press) argue that initially such theories may be relatively general or vague, and essentially function as guiding ideas. Many of the theories of suicide are middle level theories focusing on the significance of a single causal factor.

Comprehensive theories are described by Ward and Hudson (in press) as multifactor in nature. These theories tend to focus upon distal causal factors, but still include reference to proximal causal factors. A multifactor theory aims to clearly describe and specify the causal factors and examine the relationships between these factors. Ward and Hudson, point out that there is an important difference between a multifactor theory and a theoretical framework, as the latter is designed to provide a loose set of constructs from which to approach empirical problems. However, unlike a multifactor theory, this does not provide a detailed analysis of the relationships amongst the different causal factors or the varying processes.

Many of the theories of suicide which could be said to be aiming to be comprehensive would appear to be under-developed according to the criteria set out by Ward and Hudson (in press). For example, most of them tend to deal with factors within the bounds of one discipline or sub-discipline. Perhaps one of the most useful comprehensive-like theories is that offered by Shneidman (1985) and for this reason it is examined here as an illustration. Shneidman's aim was to

provide a summation of the key psychological findings on the common internal psychological states leading to suicide.

Shneidman identified ten commonalities which reflected his definition of suicide as a "multidimensional malaise in a needful individual" (Shneidman, 1985, p. 203). As argued above, definitions of suicide are crucial to the development of theories of suicide. In Shneidman's case, for example, his definition excluded a certain type of suicide accepted in this study - the spy who chooses to take his or her own life in order not to betray an important secret. Thus Shneidman's third commonality, that the stimulus of suicide is intolerable psychological pain, is not applicable to people who kill themselves in response to other stimuli. This limits the applicability of his view.

Nevertheless, Shneidman provided an excellent account of the common internal psychological states relevant to the vast majority of contemporary suicides. These states are in effect a set of proximal psychological vulnerability factors. Shneidman's achievement has included an indication of the relationships between these states. An account of the ten commonalities will be given at this point because of their potential contribution to a global theory of suicide, which is discussed below.

1. The common purpose of suicide is to seek a solution. This, the first of Shneidman's (1985) commonalities, is based upon the notion that suicide is not a random, pointless, or

purposeless act. To the sufferer, it seems to be the only available answer. Its purpose is to seek a solution to a perceived crisis - the problem of overwhelming pain which has generated intense suffering. This notion was first postulated by Jean Baechler (1979) who viewed suicide as a response to a situation that obliges a person to take up a position and find a way out (see also Beck, Rush, Shaw & Emery, 1979; Levenson, 1974; Levenson & Neuringer, 1971; Orbach, Rosenheim & Hary, 1987; Patsiokas, Clum & Luscomb, 1979). The implication of this psychological state is that in order to understand suicide it is important to understand the problem it was intended to resolve.

2. The common goal of suicide is the cessation of consciousness. Suicide may be understood not so much as a movement toward the idea of death, as a cessation, or the complete stopping of one's painful consciousness. In addition to unbearable pain, suicide also involves the individual's unwillingness to tolerate that pain, the decision not to endure it, combined with the active will to stop it. The moment that the idea of actively stopping consciousness occurs in the mind is considered to be the point at which the igniting element sets the suicidal scenario in motion.

3. The common stimulus in suicide is intolerable psychological pain. If cessation is what the suicidal person is moving toward, pain is what that person is seeking to escape. In close analysis, suicide can be understood as a

combined movement toward cessation and a movement away from intolerable emotion. This intolerable pain or sense of anguish is often termed "metapain" - the pain of feeling pain. Several theorists state that psychological pain is almost always the driving force behind suicides and consequently viewed as the centre of suicide (Maltsberger, 1992; Motto, 1992; Shneidman, 1992; Yufit & Benzies, 1973).

4. The common stressor in suicide is frustrated psychological needs. The psychological pain that is central to suicide is driven, created by, and sustained by frustrated, blocked, or thwarted psychological needs. Every suicide seems logical to the person who commits it. Suicide is not so much as an unreasonable act as it is a reaction to unfulfilled psychological needs.

Murray's (1938) list of human needs include the need for achievement, affiliation, harm-avoidance, understanding, autonomy and counteraction. It is argued that most suicides usually represent a combination of two or more such needs (e.g., Cantor, 1976; Hendin, 1965; Seiden, 1966; Tucker and Cantor, 1975) and there is some cross-national support for this (Barrett and Franke, 1970; Hendin, 1965; Lester, 1968; Lester, 1984; Rudin, 1968).

5. The common emotion in suicide is helplessness-hopelessness. It is argued that while in the suicidal state, there is a pervasive feeling of helplessness-hopelessness. The suicidal person may feel that there is nothing they can

do and that there is no one who could possibly help. Underlying all of the emotions - hostility, guilt, shame, - is the emotion of feeling helpless-hopeless.

These feelings of hopelessness-helplessness and powerlessness are often characteristics of depression (Lester, 1988). There are many theories of depression, of which two focus heavily on suicide. Seligman (1975) proposed a learned helplessness model of depression, in which he asserted that the component symptoms of depression are consequences of the person having learned that outcomes are uncontrollable. If a person learns that there is no relationship between the action they adopt and the outcome, the result is a feeling of helplessness.

Aaron Beck (1967) proposed a different model of depression in which a salient feature is that depressed people tend to accept personal responsibility for failures and negative outcomes. Such beliefs may in some cases approach delusional proportions. According to Beck, this self-blame often leads to desires of self-punishment. Beck (1967) has shown that these symptoms of depression increase with the severity of the depression.

6. The common cognitive state in suicide is ambivalence. Freud emphasised the notion that something can be both A and non-A or, to put it another way, an individual can both love and hate the same person. Shneidman (1989) suggests that the prototypical suicidal state is one in which

an individual cuts his or her throat and cries for help at the same time, and is genuine in both of these acts. Many theorists argue that no one univalently wishes to commit suicide. The individual would be happy not to do it, if they did not have to.

7. The common perceptual state in suicide is constriction. Suicide may be viewed as a more or less transient psychological constriction of affect and intellect. Synonyms for "constriction" would be "tunnelling", "focusing" or "narrowing" of the range of options usually available to that individual's consciousness when the mind is not panicked into dichotomous thinking. For example, the individual perceives that they need a magically good solution or else the alternative is cessation - an all or nothing mind state. Some have argued that considerations such as the usual life-sustaining images of loved ones are not even within the mind (Beck and Weishaar, 1992; Shneidman, 1992). Ideally the mind should be capable of scanning a range of options greater than two to make a decision as important as taking one's life.

Contemporary theories stem predominantly from George Kelly's (1955) personal construct theory in which he proposed a theory of the structure of the mind based upon cognitive (thinking) processes. His basic idea was that we attempt to interpret and make sense of the events that we experience. Our psychological processes and our behaviours are determined by the way in which we anticipate events.

At the highest level of abstraction, the person may be seen to have a theory of the world or, as Kelly (1955) termed it, a "construction system". Kelly suggested that individuals seek to extend and refine their construction system as they encounter more and more experiences, their aim being to try to make more accurate predictions for future events. In this sense Kelly's personal construct theory is a growth-oriented theory in which a person becomes more skilled in making sense of their world.

In 1961 Kelly wrote specifically on suicide. He first stressed that suicide, like most of the other behaviours of a person, was an attempt to validate their life. He suggested that the suicide will be consistent with the person's construct system and serve to reinforce the particular theory that the person has adopted. Secondly, he noted that the suicide will occur when the future is anticipated to be unpleasant and painful, a fatalism which causes the individual to lose sight of any hope (Kelly, 1961). Kelly's third point stated that suicide, like depression, was an act of extreme constriction. In constriction, the person shrinks his or her world to a manageable size. Kelly viewed the difference between a depressed person and a suicidal one as related to the degree of the constriction that occurs, such as withdrawing from certain activities as opposed to withdrawing from absolutely everything, as in cessation.

Research following on from Kelly's ideas, investigated whether suicidal people have a tendency to think in terms of

absolute value dichotomies. This tendency would result in the individual polarising his or her evaluations into extreme values, such as good versus bad or right versus wrong. Neuringer (1967) found that the suicidal people did tend to be more dichotomous in their thinking. A previous study by Neuringer (1964) showed that in addition to thinking in a dichotomous manner suicidal patients also behaved significantly more rigidly in their thinking. Patsiokas et al. (1979) replicated this line of inquiry and also found suicidal people to be more rigid as compared to nonsuicidal psychiatric patients.

In addition, several researchers have found that suicidal people are more present-oriented and have less future time perspective (Greaves, 1971; Neuringer, et, al., 1971; Yufit and Benzies, 1973). This is consistent with the notion of constriction, since the suicidal person would be restricting thoughts of the future into their consciousness.

8. The common action in suicide is escape or egression. Egression is a person's intended departure from a region of distress. Suicide is the ultimate escape, besides which running away from home, quitting a job, deserting an army, leaving a spouse, are pale actions. However, it is wise to distinguish between the wish to get away and the need to stop it for real. The point of suicide is a radical and permanent change of scene, the action to effect it is to leave (Shneidman, 1989).

9. The common interpersonal act in suicide is communication of intention. One of the most interesting findings from large numbers of psychological autopsies of clearly suicidal deaths was that there were clues to the impending lethal event in approximately eighty percent of suicidal deaths (Maris, 1992). Individuals intent on committing suicide, albeit ambivalently minded about it, consciously or unconsciously emit signals of distress, whimpers of helplessness, pleas for response, opportunities for rescue in the usually dyadic interplay that is an integral part of the suicidal scenario. The common interpersonal act of suicide is paradoxical communication of intention with the usual verbal and behavioural clues (Shneidman, 1992).

10. The common consistency in suicide is with life long coping patterns. Initially, because suicide is an act that, by definition, has not been committed by an individual before, there seems to be no precedent to it. Yet there are some deep consistencies with regard to lifelong coping patterns. Theorists such as Yufit and Bongar (1992) suggest that an individual may live a "suicidal career" resulting from an ineffective coping style which has lead to chronic stress that has accumulated slowly. Triggering events are usually not substantially different from the chronic stressors in the person's life. Thus, when the suicide threshold is crossed, friends and relatives of the person who commits suicide may not notice anything special going on and

often express surprise that the death occurred when it did (Maris, 1992).

These ten commonalities encapsulate a wide range of research findings that have arisen out of psychological studies of suicide. The internal psychological states described and the inter-relationships indicated provide a key starting point for a comprehensive theory focusing on proximal factors. Ward and Hudson (in press) characterise comprehensive theories as focusing on distal factors. The incorporation of links to distal factors within Shneidman's theory will increase its value in a more comprehensive understanding of suicide. This issue will be examined in more detail below after the discussion of the nature of global theories.

The fourth level of theory referred to by Ward and Hudson (in press) is that of the global. A global theory consists of an overarching theory composed of all previous three levels linked together. According to Ward and Hudson, a utopian global theory should be able to specify certain factors, and explain the mechanisms involved in their generation and detail their inter-relationship.

A global theory includes both distal and proximal causal factors. In the more abstract dimensions of the theory, it should be clear how distal factors such as developmental variables lead to the acquisition of personality and behavioural characteristics that ultimately result in the phenomenon. It is also necessary to specify the role and

nature of maintaining factors, and account for any escalation of the phenomenon in terms of frequency or severity. The explicit acknowledgement of any limiting factors should also be part of a global theory. Ultimately a global theory should be one theory with numerous integrated components which were previously separate middle level and comprehensive theories.

What can we expect from a global theory of suicide? If a global theory can be developed, will it provide the explanation for all suicides? According to the realists, psychological and social reality consists of open systems. Thus while it is possible to provide a theoretical account of significant causal factors of suicide, it is impossible to say exactly if someone will commit suicide and when. There are too many factors interacting in too complex ways and it is impossible to anticipate what any individual will do at any particular time. Major studies in the prediction of suicide highlight this dilemma (e.g., Maris, Berman and Maltsberger, 1992). Furthermore, one of the major challenges for a global theory is to encompass the different ontological levels relevant to an understanding of suicide. To date, it has proven extremely difficult for theorists to provide a clear account of the relationship between these levels.

From a positivist point of view, scientific explanation depends on the discovery of relevant laws. The realists have criticised the positivist covering-law model of scientific explanation and its allied hypothetico-deductive model of

theory for their assumption that human behaviour is governed by laws (Manicas and Secord, 1983). A global theory should therefore not be expected to provide universal and all-encompassing explanations.

Furthermore, it has been argued above that different types of suicide require different types of explanation. Not all suicides are the same. A theory that attempted to be applicable to them all would therefore either consist of simply an aggregate of different theories or a highly generalised account of a range of causal factors which may or may not be relevant to any particular type of suicide. The latter possibility offers in effect what the realists refer to as a conceptual framework (Sayer, 1984). Such a conceptual framework provides a conceptualisation of the key mechanisms - factors and relationships - relevant to an understanding of a phenomenon.

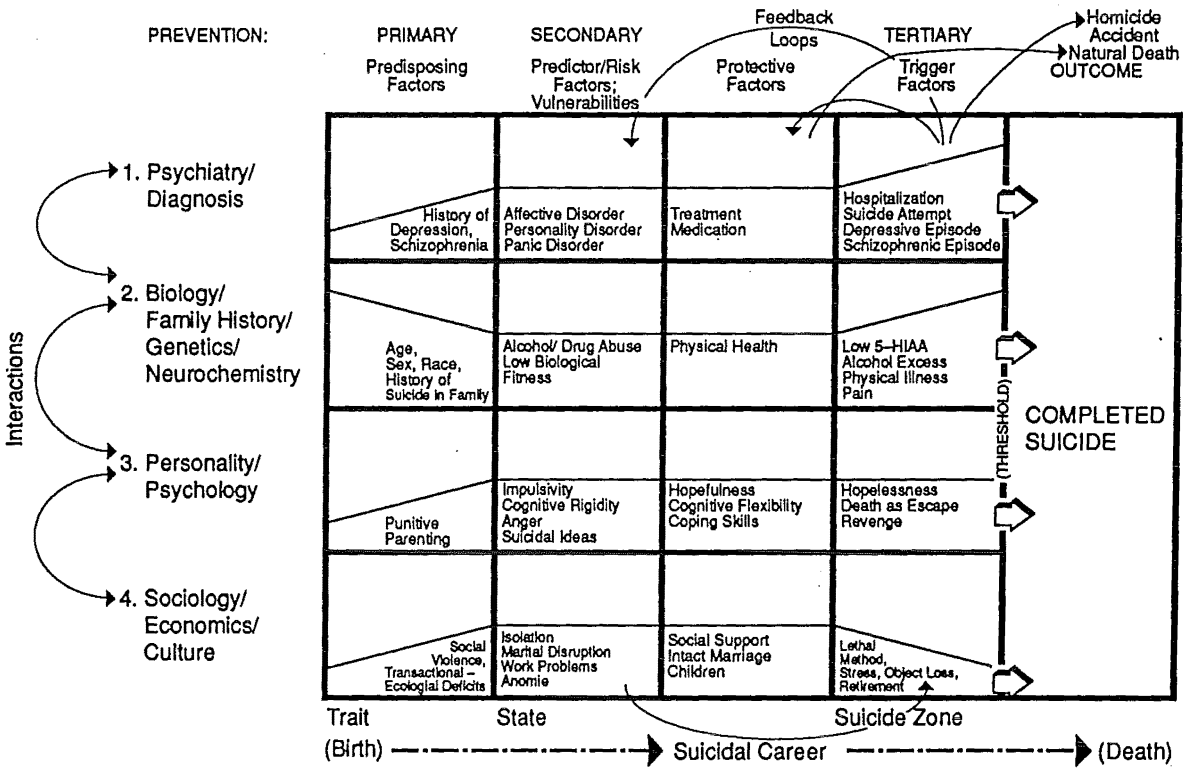
There has been no attempt to date to develop a global theory of suicide. This has largely been due to the multitude of factors and disciplines involved. Perhaps the closest attempt at a global theory are the rather tentative suggestions by Maris, Berman and Maltsberger (1992) at providing an overview of suicidology. Their overview in effect offers a conceptual framework in the realist sense.

Maris, Berman and Maltsberger (1992) were attempting to summarise a range of concerns encountered by researchers dealing with the assessment and prediction of suicide. They

referred to their overview as a general model to guide research. Their views are represented in a diagram and one and a half pages of text. The diagram is based on the four disciplines and a range of factors of interest in the understanding of assessment and prediction (see Figure 6). These factors included "predisposing factors" (distal factors), "vulnerabilities" (proximal factors on the continuum between distal and proximal factors) and "trigger factors" (proximal factors). The theorists emphasised the complexity, multidisciplinarity and interactive character of factors relevant to an understanding of suicide. They conceded that their theory was not sufficiently specified - "most individuals who 'fit' the model will not complete suicide" (Maris, Berman and Maltsberger, 1992, p. 669). This, of course, reflects the contention made above about the difficulties, if not the impossibility, of achieving anything near complete explanation.

There are at least two areas in which the general theory suggested by Maris, Berman and Maltsberger (1992) could be improved. In the first place, the approximate relative importance indicated for the sets of disciplinary factors could be disputed. For example, it could be argued that psychological trigger factors such as hopelessness are more significant relative to biochemical trigger factors such as low 5-HIAA levels. Secondly, the fact that there are links or interactions between the four sets of disciplinary factors is simply stated without any elaboration. The points made above about the relationship between disciplines and

Figure 6 : A General Model of Suicidal Behaviours ...."Relative height of the line within each domain indicates approximate importance of those factors at the different stages of the suicidal career." (Maris, Berman & Maltsberger, 1992, p. 668).



ontological levels, and about the problematic nature of reductionistic notions of causation between ontological levels, are not recognised.

Research question four asked: is it possible to develop an integrated overall theory of suicide? It has been argued that a global theory is possible but only in the sense of a conceptual framework, a highly generalised account of a range of distal and proximal factors which may or may not be relevant to any particular type of suicide. The distal

factors relevant to a person's predisposition to suicide exist at all three ontological levels - the biochemical, the psychological and the social. Such factors have been identified in the literature on suicide and many of them have been noted above in the discussion of the factors dealt with in the four disciplines - biological, psychiatric, psychological and sociological. The significance of different distal factors is often difficult to determine because different basic theoretical perspectives have tended to overemphasise one factor at the expense of others.

It has been suggested that Shneidman's (1985) ten common internal psychological states specify a set of psychological proximal vulnerability factors. In the presence of proximal trigger factors, which may occur as events at any of the three ontological levels, and given the opportunity to take one's life (by having at hand the means to do so, for example), the vulnerability factors can lead to the act of suicide.

CHAPTER VI

CONCLUSION

The first research question addressed in this thesis was that of the definition of suicide. In chapter two it is suggested that to commit suicide is to end one's own life intentionally. Such a definition highlights the intentionality of suicide and distinguishes it from accidental self-inflicted death. However, a three-way distinction has to be drawn in order to exclude a certain kind of intentional death from the category of suicide. In one instance, death can be intended as an end in itself. In another instance, it can be intended as a means to an end. In a third instance, such as that of the lifeboat martyr, death may not be intended at all but foreseen as a consequence of what else is intended. It is argued that this third instance does not constitute suicide because if death does not occur, the individual's intentions are not thwarted.

Whereas a definition provides a sense of conceptual unity and uniqueness, typologies indicate complexity and differentiation. The last half of chapter two examines typologies of suicide in order to demonstrate the variability within the suicide phenomenon. It is suggested throughout the thesis that different types of suicide differ to such an extent that different kinds of explanations are required. This in turn makes the theorisation of suicide particularly challenging.

There exists a proliferation of theories of suicide in the literature. The second research question examined in the thesis asks why this proliferation occurs. In chapter three, three main sources of proliferation are identified. The first is the multiplexity of suicide, that is, the fact that it is a complex phenomenon that can only be explained by reference to a multitude of factors. Each person who commits suicide follows their own pathway, although similar pathways can be identified. The second is the existence of different disciplinary approaches. Four of these are identified: biological, psychiatric, psychological and sociological. Often sub-disciplines of these four provide their own theories as well. The third main source is the existence of a range of different basic theoretical perspectives. Such perspectives in psychology as structuralism, functionalism, behaviourism, the cognitive and psychoanalytic approaches, and feminism all provide different ways to approach an understanding of psychological phenomena. Furthermore, different perspectives on the nature of science, theory and explanation exist. These different basic theoretical perspectives contribute to the proliferation of theories of suicide.

Whether this proliferation of theories of suicide represents an acceptable form of theoretical pluralism or should be replaced by theoretical unification constitutes the third research question of the thesis. In chapter three it is argued that some of the theories of suicide are complementary

in character. In other words, they deal with different sub-domains of suicide, whether they be different types of suicide or different possible explanatory factors. Theoretical unification in the positivist sense would in effect deny the multiplexity of suicide by treating it as one undifferentiated domain.

Another aspect of theoretical pluralism in the study of suicide arises from the application of different basic theoretical perspectives. Competitive theories from different perspectives may be offered to explain the same sub-domain. Theoretical unification of these theories would represent the authoritarian imposition of one perspective at the expense of others. For this reason as well as the reason mentioned in the previous paragraph, it is argued in chapter three that theoretical pluralism should be viewed as acceptable and that there are distinct limits to theoretical unification.

The fourth research question asks how studies of the various explanatory factors have been shaped by different disciplinary concerns and by the assumptions of different basic theoretical perspectives. Chapter four provides an extended discussion of the factors dealt with by the four main disciplines active in the study of suicide. These disciplines have focussed on the operation of different factors and usually have failed to take into account the multidisciplinary character of suicide. Suicide has a number of ontological levels to it. The biochemical, psychological

and sociological levels are all intrinsic to suicide but disciplinary approaches tend to ignore other levels than the one relevant to the discipline involved.

In chapter four, the opportunity was taken to note that different basic theoretical perspectives are also operative especially in psychology and sociology. One of the main challenges in the theorisation of suicide is to resist the fragmentation of disciplines, theoretical perspectives, reductionisms and over-emphasised factors in order to grasp suicide as a holistic phenomenon.

The fifth research question then arises: is it possible to develop an integrated overall theory of suicide? In chapter five, the positivist understanding of a global theory is rejected. In the positivist view, such a theory provides a universal and all-encompassing explanation. It is argued that different explanations are required for different types of suicide, that human behaviour is not law-governed as the positivists assume, and that psychological and social reality consists of open systems unable to be finally determined.

The realist sense of a global theory as a conceptual framework is viewed as more acceptable. Such a global theory consists of a highly generalised account of the range of distal and proximal factors which potentially are relevant to any particular type of suicide. The distal factors relevant to why a person commits suicide exist at all three ontological levels. It is suggested in chapter five that

Shneidman's (1985) ten common internal psychological states specify a set of psychological proximal vulnerability factors which are a necessary element of any global theory of suicide (although a problem was noted with Shneidman's third commonality arising out of his more restrictive definition of suicide). Such vulnerability factors can lead to the act of suicide upon the occurrence of proximal trigger factors (which may also consist of events at any one of the three ontological levels) and in the presence of the opportunity and means to take one's life.

Chapter one opened with a reference to the search by Cathy for a satisfactory explanation for her husband's suicide. It was clear to her that her husband's low self-esteem was a very significant contributor to his decision to take his own life. Low self-esteem had caused him to become dissatisfied with the way he was providing for his family. To Cathy, her husband's dissatisfaction was unjustified but it caused him to become depressed and moody, hopeless and helpless, and, eventually, to kill himself.

However, there were two questions left in Cathy's mind: what was the origin of her husband's low self-esteem and why did he kill himself when others with low self-esteem did not? These two questions point to two directions of interest in the theorisation of suicide - the causes of psychological states leading to suicide and the triggers of suicide. The first direction leads to a consideration of a wide range of factors at a number of different ontological levels, factors

that have been identified in this thesis as distal in character. The second direction leads to a consideration of a range of less-clearly determinable possibilities at the proximal pole of the distal-proximal continuum.

This account of the relationship between factors relevant to an understanding of the suicide of Cathy's husband illustrates the role that theory can play in clarifying the complex causation of suicide. The large research programme conducted by the Canterbury Suicide Project needs to draw more explicitly upon such theorisation if it is to make sense of the range of factors it has identified as significant in contemporary suicide in New Zealand.

This thesis has raised questions and suggested directions rather than provided answers. It has not offered a detailed global theory of suicide. Instead, it has outlined what are considered to be central elements of such a theory - a conceptual framework providing a highly generalised account of a range of causal factors which may or may not be relevant to any particular type of suicide. A global theory of suicide would also acknowledge open systems, recognise different ontological levels, and encompass the range of different disciplines. It would specify predisposing factors, vulnerabilities and trigger factors. Significant progress towards a fuller understanding of suicide depends on further theorisation along these lines.

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